SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Filing at a Glance

Company: HM Life Insurance Company

Product Name: Stop Loss	SERFF Tr Num: HMRK-126833775	State: Arkansas
TOI: H12 Health - Excess/Stop Loss	SERFF Status: Closed-Approved-Closed	State Tr Num: 46907
Sub-TOI: H12.004 Self-Funded Health Plan	Co Tr Num: HL601-SL (810)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Jennifer Bayich	Disposition Date: 10/11/2010
	Date Submitted: 09/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Stop Loss 8/10	Status of Filing in Domicile: Not Filed
Project Number: HL601-SL (8/10)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Exempt from filing in PA.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 10/11/2010	Explanation for Other Group Market Type:
	State Status Changed: 10/11/2010
Deemer Date:	Created By: Jennifer Bayich
Submitted By: Jennifer Bayich	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for filing with your department are the captioned forms. When approved, Policy Form HL601-SL (810), et. al. will replace existing business issued on the following forms, at the next renewal following the date of approval:

Form	Approved
HL601-SL (905)	10/19/05 (paper filing)
HL601-SL/DP (905)	10/19/05 (paper filing)
HL601-SL (905) AFR	10/19/06 (paper filing)
HMP-SL 710, et. al.	8/5/10 (SERFF Tracking ID- HMRK 126728949)

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

These forms will also be used for new business issued after the date of approval. Previously approved (10/19/05) Application and Disclosure forms HL-SLA WD and HL-SLA ND, will continue to be used with HL601(810),et.al. HL-SLA WD will be used in those instances when disclosure is required and HL-SLA ND when disclosure is not required.

The forms provide stop loss insurance for groups that retain the services of a third party administrator (TPA). In order to accommodate our policyholders' specific needs, we request that these forms be approved as variable on a general-use basis.

Enclosed with this submission you will find a Policy Variables Format Memorandum, which provides explanations for how any of the bracketed language will be altered. You have our assurance we will not add to or revise any language, but only remove language in the manner described in the memorandum. Any variability will be administered within your state's requirements.

The forms contain no unusual or controversial items, according to normal company and industry standards. To the best of my knowledge, the forms comply with all of your applicable statutes.

Should you have any questions or concerns, please do not hesitate to contact me. I may be reached directly at the left-side address, as well as via telephone at 412-544-0923, via fax at 412-544-1138, or via e-mail to jennifer.bayich@hminsurancegroup.com.

Thank you for your time and attention to this matter.

Sincerely,
Jennifer L. Bayich, Esq.
Compliance Analyst III

Enclosures

Company and Contact

Filing Contact Information

Jennifer Bayich, Compliance Analyst II
P.O. Box 535061
jennifer.bayich@hminsurancegroup.com
412-544-0923 [Phone]

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

P6504 412-544-1138 [FAX]

Pittsburgh, PA 15235-5061

Filing Company Information

HM Life Insurance Company	CoCode: 93440	State of Domicile: Pennsylvania
PO Box 535065	Group Code: 812	Company Type:
Suite P6504	Group Name: HM Insurance Group	State ID Number:
Pittsburgh, PA 15253-5065	FEIN Number: 06-1041332	
(412) 544-1139 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$950.00
Retaliatory?	No
Fee Explanation:	19 forms x $50 = $950
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	$950.00	09/27/2010	39913485

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/11/2010	10/11/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/08/2010	10/08/2010	Jennifer Bayich	10/11/2010	10/11/2010

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Disposition

Disposition Date: 10/11/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	AR Submission Letter	Approved-Closed	Yes
Supporting Document	Summary of Variables	Approved-Closed	Yes
Supporting Document	response letter	Approved-Closed	Yes
Form *(revised)*	Stop Loss Insurance Policy	Approved-Closed	Yes
Form	Aggregate Advance Funding Rider	Approved-Closed	Yes
Form	Aggregating Specific Loss Fund Rider	Approved-Closed	Yes
Form	Aggregate Terminal Liability Rider	Approved-Closed	Yes
Form	Family Aggregating Specific Loss Fund Rider	Approved-Closed	Yes
Form	Family Specific Advance Funding Rider	Approved-Closed	Yes
Form	Bridge Renewal Rider	Approved-Closed	Yes
Form	Monthly Aggregate Accomodation Rider	Approved-Closed	Yes
Form	Medical Travel Rider	Approved-Closed	Yes
Form	Rate Cap Rider	Approved-Closed	Yes
Form	Rate Guarantee Rider	Approved-Closed	Yes
Form	Specific Advance Funding Rider	Approved-Closed	Yes
Form	Affiliate Rider	Approved-Closed	Yes
Form	Continuous Aggreate Accomondation Rider	Approved-Closed	Yes
Form	Renewal Rider	Approved-Closed	Yes
Form	Step-Down Specific Deductible Rider	Approved-Closed	Yes
Form	Special Risk Limitation Rider	Approved-Closed	Yes
Form	Specific Terminal Liability Rider	Approved-Closed	Yes
Form	Cancer Clinical Trial Rider	Approved-Closed	Yes
Form	Stop Loss Insurance Policy	Replaced	Yes

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/08/2010
Submitted Date	10/08/2010
Respond By Date	

Dear Jennifer Bayich,

This will acknowledge receipt of the captioned filing.

Objection 1

- Stop Loss Insurance Policy, HL601-SL (810) (Form)

Comment:

Under exclusions, there is an exclusion for war. Under the definition of war, there is an option that states that the term includes Acts of Terrorism. Our Department is not approving Terriorism or Terrorism type exclusions in any form of insurance.

Since this is variable information, please certify that this exclusion will not be used in Arkansas.

Thank you for your understanding in this matter.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/11/2010
Submitted Date	10/11/2010

Dear Rosalind Minor,

Comments:
Thank you for your review of this filing.

Response 1

Comments: The War exclusion has been revised to remove the option of excludinf acts of terrorism.

Related Objection 1

Applies To:

- Stop Loss Insurance Policy, HL601-SL (810) (Form)

Comment:

Under exclusions, there is an exclusion for war. Under the definition of war, there is an option that states that the term includes Acts of Terrorism. Our Department is not approving Terriorism or Terrorism type exclusions in any form of insurance.

Since this is variable information, please certify that this exclusion will not be used in Arkansas.

Thank you for your understanding in this matter.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: response letter
Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Stop Loss Insurance	HL601-SL		Policy/Contract/Fraternal	Initial		56.000	Policy

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Policy	(810)	Certificate			Form HM 601-SL _810_ clean.pdf

Previous Version

Stop Loss Insurance Policy	*HL601-SL (810)*	*Policy/Contract/Fraternal Certificate*	*Initial*	*56.000*	Policy Form HL601-SL (810) clean.pdf

No Rate/Rule Schedule items changed.

Please of advise of any further questions or concerns.
Thank you.

Sincerely,
Jennifer Bayich

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Form Schedule

Lead Form Number: HL601-SL (810)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/11/2010	HL601-SL (810)	Policy/Contract/Fraternal Certificate	Stop Loss Insurance Policy	Initial		56.000	Policy Form HM 601-SL _810_ clean.pdf
Approved-Closed 10/11/2010	HM AAF (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Advance Funding Rider	Initial		0.000	Rider HM AAF 810 clean.pdf
Approved-Closed 10/11/2010	HM ASLF (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregating Specific Loss Fund Rider	Initial		0.000	Rider HM ASLF (810) clean.pdf
Approved-Closed 10/11/2010	HM ATL (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Aggregate Terminal Liability Rider	Initial		0.000	Rider HM ATL (810) clean.pdf

SERFF Tracking Number:	*HMRK-126833775*		*State:*	*Arkansas*		
Filing Company:	*HM Life Insurance Company*		*State Tracking Number:*	*46907*		
Company Tracking Number:	*HL601-SL (810)*					
TOI:	*H12 Health - Excess/Stop Loss*		*Sub-TOI:*	*H12.004 Self-Funded Health Plan*		
Product Name:	*Stop Loss*					
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*					
Approved-Closed 10/11/2010	HM FASLF	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Family Aggregating Specific Loss Fund Rider	Initial	0.000	Rider HM FASLF clean.pdf
Approved-Closed 10/11/2010	HM FSAF	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Family Specific Advance Funding Rider	Initial	0.000	Rider HM FSAF clean.pdf
Approved-Closed 10/11/2010	HM GR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Bridge Renewal Rider	Initial	0.000	Rider HM GR clean.pdf
Approved-Closed 10/11/2010	HM MAA (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Monthly Aggregate Accomodation Rider	Initial	0.000	Rider HM MAA (810) clean.pdf
Approved-Closed	HM MTR	Policy/Contract/Fratern	Medical Travel Rider	Initial	0.000	Rider HM MTR

10/11/2010		al Certificate: Amendment, Insert Page, Endorsement or Rider				clean.pdf
Approved-Closed 10/11/2010	HM RC	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Rate Cap Rider	Initial	0.000	Rider HM RC clean.pdf
Approved-Closed 10/11/2010	HM RG	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Rate Guarantee Rider	Initial	0.000	Rider HM RG clean.pdf
Approved-Closed 10/11/2010	HM SAF (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Advance Funding Rider	Initial	0.000	Rider HM SAF (810) clean.pdf
Approved-Closed 10/11/2010	HM SLAR	Policy/Contract/Fraternal Certificate:	Affiliate Rider	Initial	0.000	Rider HM SLAR clean.pdf

		Amendment, Insert Page, Endorsement or Rider					
Approved-Closed 10/11/2010	HM SLCAA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Continuous Aggreate Accomondation Rider	Initial		0.000	Rider HM SLCAA clean.pdf
Approved-Closed 10/11/2010	HM SLR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Renewal Rider	Initial		0.000	Rider HM SLR clean.pdf
Approved-Closed 10/11/2010	HM SLSD	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Step-Down Specific Deductible Rider	Initial		0.000	Rider HM SLSD clean.pdf
Approved-Closed 10/11/2010	HM SRL	Policy/Contract/Fraternal Certificate: Amendment, Insert	Special Risk Limitation Rider	Initial		0.000	Rider HM SRL clean.pdf

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*		
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*		
Company Tracking Number:	*HL601-SL (810)*				
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*		
Product Name:	*Stop Loss*				
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*				

		Page, Endorsement or Rider				
Approved-Closed 10/11/2010	HM STL (810)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Specific Terminal Liability Rider	Initial	0.000	Rider HM STL (810) clean.pdf
Approved-Closed 10/11/2010	HM CCT	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Cancer Clinical Trial Rider	Initial	0.000	Rider HM CCT clean.pdf

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

POLICY NUMBER	[SPECIMEN]
NAME OF POLICYHOLDER	[SPECIMEN]
TYPE OF COVERAGE	Stop Loss Insurance
EFFECTIVE DATE	[SPECIMEN]
POLICY TERM	[DATE through DATE]
POLICY DELIVERED IN	[STATE] and governed by the laws of that state.

HM Life Insurance Company agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are actually Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

This Policy begins at 12:01 AM current [Eastern] Time on the first day of the current Policy Term and ends at 11:59 PM current [Eastern] Time on the last day of the current Policy Term, and may be renewed for subsequent Policy Terms. {Option :} If this Policy is renewed the terms and conditions of this Policy may be revised.

This Policy will terminate automatically upon the failure of the Policyholder to pay any premium within the Grace Period. Termination of this Policy for any reason other than non-payment of premium will occur following written notice by the Policyholder or us.

All provisions on this and the following pages are a part of this Policy. The definitions of terms apply whenever the terms are used anywhere in this Policy. "We", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

HM Life Insurance Company

By

President

This Policy is Non-Participating

TABLE OF CONTENTS

Part 1. DECLARATION PAGE

{Option, used on renewal if Declaration Page is replaced :}
[This Declaration Page replaces the Declaration Page for Policy Number and Policyholder shown in A. Policy Information below the for the Policy Term **[(1)]** through **[(1)]** in its entirety.]

A. POLICY INFORMATION

1.	Policy Number	[Specimen]
2.	Policyholder	[Specimen]
3.	Current Policy Term	[Date] through [Date]
4.	Covered Underlying Plan(s)	[Policyholders] [See] [and] [Affiliates]
5.	Claims Administrator	[Specimen]

{Option – Specific Benefit Schedule :}
[A.] SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually-Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid prior to [Date].

{Option – initial 12/15; current Policy Term revised to 12/24 at renewal :}
[NOTE: If you renew this Policy the Covered Claims Basis for this Policy Term will be revised so that Eligible Claim Expenses include only such expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option - Bridge Renewal :}
During the current Policy Term, any Eligible Claim Expense Incurred prior to the end of that term but actually Paid after the current Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the renewal Policy Term; as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the Incurred Period and Paid during the Run-out Period for the renewal Policy Term will be considered an Eligible Claim Expense for purposes of that renewal Policy Term.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the renewal Incurred Period but actually paid after the renewal Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the subsequent Policy Term as such, those expenses are subject to all terms and conditions of the Policy

including but not limited to re-satisfying the Specific Deductible.

As used above:

"Run-out period" is the {Options :} [three] [six] month period immediately following the end of the current or any subsequent Policy Term.

"Incurred Period" is the period from [original Covered Claims basis incurred date] to the end of the current Policy Term.

2. Specific Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single Covered Unit	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Specific Deductible

{Option – standard offer :}
[Per Participant] $[*]

{Option :}
[Per Family] $[*]

5. Specific Payable Percentage (in excess of Specific Deductible) [*] **%**

{Option - Domestic Claims}
[6.] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] **%]**

[7.] Maximum Specific Benefit

{Option – standard offer :}
[Per Participant in excess of the Specific Deductible]

{Option :}
[Per Family in excess of the Specific Deductible]

{Option :}
[Per Policy Term] [None] [$ [*]]

{Option – standard offer :}
[Per Lifetime] [Unlimited] [$ [*]]

{Option – Aggregate Benefit Schedule :}

[B.] AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid from [Date] through [Date].

2. Aggregate Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Aggregate Payable Percentage (excess of Deductible): [*] %

{Option – may be removed if the corridor is a function of the monthly aggregate deductible calculation :}

[5.] [Aggregate Attachment Point (Corridor) [*] %]

{Option :}

[6.] [Minimum Aggregate Deductible $[*]]

[7.] Annual Aggregate Deductible

{Option – only used if a monthly aggregate deductible is not calculated :} [$[*]]

{Option, standard offer :}
[is equal to [A], [B] or [C] whichever is greater, where:

{Option - either A, B or both may be included:}
[A] [= The Monthly Aggregate Deductible Amount for the initial Policy Month times * the number of months in the current Policy Term]

{Option :}
[B] [= The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month [in] the current Policy Term]

{Option :}
[C] = [The Minimum Aggregate Deductible]

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the Aggregate Monthly Deductible Amounts have been calculated for each Policy Month of the Policy Term.

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the end of the Policy Term.

{Option – only used if a Monthly Aggregate Deductible is computed:}
[8.] [Monthly Aggregate Factor

{Option :}
[Per Single Covered Unit per Policy Month] $[*]

{Option :}
[Per Single Plus One Covered Unit per Policy Month] $[*]]

{Option :}
[Per Single Plus Two Covered Unit per Policy Month] $[*]]

{Option :}
[Per Family Covered Unit per Policy Month] $[*]]

{Option :}
[Per Composite Covered Unit per Policy Month] $[*]]]

{Option – used if aggregate claims expenses are limited :}
[9.] [Maximum Aggregate Eligible Claims Expense

{Option :}
[Per Single Covered Unit) $[*]

Option :}
[Per Single Plus One Covered Unit] $[*]]

[Per Single Plus Two Covered Unit] $[*]]

{Option :}
[Per Family Covered Unit] $[*]]

{Option :}
[Per Composite Covered Unit] $[*]]

{Option - domestic claims :}
[10] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] %]

[11.] Maximum Aggregate Benefit (in excess of the

Annual Aggregate Deductible~~)~~ per Policy Term) $[*]

[C.] PREMIUM

{Option, standard :}
[Specific Premium per Month

Single Employee:	$[*]
Single Plus One	$[*]
Single Plus Two	$[*]
Family:	$[*]
Composite:	$[*]

{Option :}
[Minimum Annual Specific Premium: $ [*]]

[Initial][Specific] Rate Guarantee Period [*] Months]

{Option :}
[Aggregate Premium per Month Per Covered Unit: $ [*]]

[Minimum Annual Aggregate Premium: $ [*]]

The Specific Premium per Month [and the Aggregate Premium per Month per Covered Unit] only apply to the current Policy Term.

{Options, see variable summary; Special Risk Limitation used to:

- Describe an Alternate Specific deductible for a Covered Units or Covered Family Units.
- Describe instances where certain claim expenses are limited (capped) excluded for the period prior to the effective date of the policy, for a period of time following either the effective date or renewal date, for the entire time the contract is in effect, for a Plan Year, etc.; this may be tailored to apply to a Participant, employee class, Affiliate, limited to certain procedures, or a group of related procedures/ conditions.
- Describe instances where Participants, all employees of a certain class, an Affiliate, etc. are excluded from the policy; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude individual or groups of individual in certain situations (i.e., COBRA participants, Medicare participants, Medicaid participants, domestic partners, late enrollees, employees of an Affiliate, employees in a certain class, etc.); this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude or place an internal limit on certain types of claims expenses; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Apply a preexisting conditions limitation; this may be limited to a dollar amount, defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, a Participant, employee class, Affiliate, etc.
- Apply a separate run-in or run-out limit to a location, affiliate or employee class :}

[D.] SPECIAL RISK LIMITATIONS:

[None]

[Specific [See variable summary]]

[Aggregate [See variable summary]]

[E.] AFFILIATES

{Option, if no affiliates "none is used; if there are affiliates name(s) of affiliates are listed; if all affiliates have the same underlying plan as the policyholder "same as policyholders is listed – if different than policyholders plan's name /designation is entered :}
[None]

[Name]	[Covered Underlying Plan(s)]
[Specimen]	[Same as Policyholders]

Part 2. BENEFITS

{Option – Specific :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule and Policy Term are shown on the Declaration Page.

{Option – Aggregate and Specific :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule or the Aggregate Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule and Aggregate Benefit] Schedule and Policy Term are shown on the Declaration Page.

{Option – Aggregate :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Aggregate Benefit, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Aggregate Benefit and Policy Term are shown on the Declaration Page.

{Option – Specific Benefit per participant:}
[A.] SPECIFIC BENEFIT

We will pay to the Policyholder the following Specific Benefits, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Participant minus (A plus B), where:

A = The Specific Deductible for the Participant

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan

Times the Specific Payable Percentage

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

{Option – Excluded Claims Expenses :}
[The Specific Benefit payable does not include any amount [actually] Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

{Option – removed with unlimited lifetime max and no policy term max}
[In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.]

{Option – Specific Benefit per family:}
[A.] FAMILY SPECIFIC BENEFIT

We will pay the Policyholder, the following Specific Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Family will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Family during the current Policy Term minus (A plus B)) where:

A = The Specific Deductible for the Family.

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Times the Specific Payable Percentage

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

{Option – Excluded Claims Expenses :}
[The Specific Benefit does not include any amount actually Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

{Option – removed with unlimited lifetime max and no policy term max}
[In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by all members of the same Family] exceed the Maximum Specific Benefit.]

{Option – standard offer; calculation includes monthly factor and a maximum aggregate eligible claims expense :}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal the total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B plus C), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

{Option – calculation does not include a monthly factor, but assumes a maximum aggregate eligible claims expense :}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term times the Aggregate Attachment Point (Corridor) minus (A plus B plus C), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Monthly Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

{Option – calculation includes monthly factor or a maximum aggregate eligible claims expense:}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term times the Aggregate Attachment Point (Corridor) minus (A plus B), where:

A = The amount actually Paid by the Policyholder in excess of the Maximum Monthly Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

Part 3. EXCLUSIONS AND LIMITATIONS

No Deductible of this Policy will be satisfied and no benefit of this Policy will be paid for:

[*] UNDERLYING PLAN: Any amount actually Paid by the Policyholder for an expense Incurred:

a. When the Covered Underlying Plan is not in effect; or

b. By a person who is not a Participant when the expense is Incurred; or

c. That is not specifically covered under the terms of the Covered Underlying Plan, or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan; or

d. Prior to the initial Incurred date shown in Covered Claims Basis on the Declaration Page.

{Option - standard, may be removed or replaced with misrepresentation upon request :}
[*] [NONDISCLOSURE: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant who:

a Was a Participant at the time of the initial underwriting of this Policy, but whose Known medical conditions were not accurately Disclosed to us at that time by the Policyholder or the Policyholder's Claims Administrator.

b. Was a Participant at the end of the Policy Term, but whose Known medical conditions were not accurately Disclosed to us by Policyholder or the Policyholder's Claims Administrator prior to the date this Policy is renewed for a subsequent Policy Term.

{Option :}
[c.] [Becomes a Participant after the {Options :} [initial underwriting] [Effective Date] of this Policy, but whose Known medical conditions were not accurately Disclosed to us before

the effective date of his or her coverage through the Covered Underlying Plan(s) by the Policyholder the Policyholder's Claims Administrator.]

{Option :}

[d.] [Becomes a Participant after the {Options :} [initial underwriting] [Effective Date] of this Policy, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator before the date the Policyholder acquires another Affiliate, establishes another class of employees eligible for coverage through the Covered Underlying Plan(s).]]

{Option, may be substituted for nondisclosure provision or removed upon request :}

[*] [MISREPRESENTATION: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant if Claim Information was requested prior to the beginning of any Policy Term], and either the requested Claim Information was not provided or the Known Claim Information provided was inaccurate or incomplete in a material respect .]

{Standard, may be removed upon request :}

[*] [OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's actual expenses.]

[*] [ADMINISTRATIVE COSTS: Any amount, which is actually Paid by the Policyholder for;

a. Administrative costs, including but not limited to, administrative costs for claim payments, networks, case management fees in excess of the usual and customary charge, PPO access fees and Prescription Drug administration fees; or

b. Capitation fees ; or

c. The expense of litigation; or

d. Extra contractual damages, compensatory damages, or punitive damages.]

{Option :}

[*] [WAR: Any amount actually Paid by the Policyholder for Eligible Claims Expenses which arise out of or are caused or contributed to by war or an act of war {Option:} [unless a Participant is required to be in a location where a war or act of war has or may occur as a condition of employment with his or her Employer].

WAR means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

{Option - version 1:}

[*] [WORK RELATED: Any amount actually Paid by the Policyholder through the Covered Underlying Plan(s) for any injury or illness which is eligible for coverage under a workers' compensation or occupational disease policy or agreement, whether or not such policy or agreement is actually in force and whether or not such benefits are received by the Participant.]

{Option - version 2:}

[*] [WORK RELATED: An injury or illness incurred or contracted in the course of any employment for wage or profit.]

{Option :}

[*] [FELONY: Any amount ~~[~~actually~~]~~ Paid by the Policyholder for Eligible Claims Expenses for any period caused or contributed to by a Participant committing or attempting to commit an assault, felony or participating in an illegal occupation, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties.]

{Option :}
[*] [FOREIGN MEDICAL CARE: Any amount incurred by a Participant for the cost of [drugs] procedures, services, supplies or treatments[, other than drugs received from a licensed Canadian pharmacy or pharmacist,] rendered or received in person[, by mail or otherwise] outside the United States if the purpose of such travel [or communication] is to obtain or receive such service, supply or treatment.]

{Option :}
[*] [USUAL AND CUSTOMARY CHARGE: Any amount which is actually Paid by the Policyholder in excess of the usual and customary charge for the Covered Service, as defined and/or applied by the Covered Underlying Plan(s).]

{Option :}
[*] [EXPERIMENTAL OR INVESTIGATIONAL: Any amount which is actually Paid by the Policyholder for the cost of drugs, procedures, services, supplies or treatments which are considered experimental or investigational.]

{Option :}
[*] [NOT MEDICALLY NECESSARY: Any amount which is actually Paid by the Policyholder for the cost of procedures, drugs, treatments, services, or supplies which are not medically necessary and appropriate, as determined by the Food and Drug Administration, the American Medical Association, their successor organization(s), or other generally accepted medical compendia.]

{Option :}
[*] [LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder [or the Policyholder's authorized representative].]

{Option :}
[*.] [RETIRED: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant.

{Option – has retired:}
who has retired[,][.]

{Option – was retired:}
who was retired[,][.]

{Option – after date eligible:}
except for any Participant who retires on or after [(specimen)] and is still covered under the Covered Underlying Plan(s).

{Option – prior to age until age eligible:}
except this limitation will not apply to any Participant who retires prior to age [65] and is still covered under the Covered Underlying Plan(s) until that person attains [65] years of age.

{Option – prior to normal retirement age:}
except this limitation will not apply to any Participant who retires prior to his or her normal retirement age and is still covered under the Covered Underlying Plan(s) until that person attains his or her normal retirement age [as defined] [by the [Policyholder].]
{Option :}

[*] [EXCESS REIMBURSEMENT: Any amount in excess of the fee, reimbursement percentage or other form of payment negotiated with a provider or facility by the Applicant[,] Policyholder [or] [Designated TPA] as total reimbursement to the provider or facility for the cost of drugs, procedures, services and supplies through the Covered Underlying Plan(s).]

Part 4. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder's agent and we will not be held liable for any act or omission of the Claims Administrator.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Claims Administrator will:

1. Supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;

2. Maintain accurate records of all claim payments;

3. Maintain separate records of expenses not covered; and

4. Provide us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

   a. notice of claims that reach 50% of the Specific Deductible; and
   b. number of Covered Units or Covered Family Units;
   c. total amount of claims paid.

5. Secure and keep renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of insurance in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator for the Policyholder.

This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

Part 5. CLAIM PROVISIONS

A. NOTICE OF CLAIM

The Policyholder or the Policyholder's Claim's Administrator must notify us within {Option :} [20] [30] days of the date:

1. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) for a Catastrophic Claim, Large Claim or Shock Loss; or.

2. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant

has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) that exceed 50% of the Specific Deductible {Option :} [, or $50,000, whichever is less].

Failure to give notice within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible. The notice to us must include:

1. The identity of or unique identifier associated with the Participant.

2. A description of the illness or accident and the prognosis.

3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan(s).

B. PROOF OF LOSS

The Policyholder or the Policyholder's Claims Administrator must provide satisfactory proof of loss to support a claim within {Options; 90 standard :} [90] [120] [180] [365] days after the end of the current Policy Term or the end of the Paid period shown in Covered Claims Basis for the current Policy Term, if later {Option :} [or as soon thereafter as reasonably possible and, in any case, within 365 days after the end of that 90 day period]. Claims not filed within {Option, used for 90 days :} [this] {Option, used if a 365 day limit applies:} [these] time limits will be denied and no benefits will be paid by us.

Upon presentation of satisfactory proof of loss the Policyholder represents that all monies necessary to pay for services and supplies have been paid to the Participant or respective providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

{Option:}
[C. PAYMENT OF CLAIM

Subject to satisfactory written proof of loss, any benefits payable under the Policy will be paid within {Options; 45 standard :} [30] [45] [60] days immediately following our written receipt of such proof of loss.]

Part 6. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change. The Policyholder or the Policyholder's Claims Administrator must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or.

2. Accept the Change and revise the Premium Rates and/or other terms and conditions of this Policy; or.

3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

{Option :}
[4.] [Not accept the Change and terminate this Policy.]

If we accept the Change we will consider the Change approved on the date of the Change.

Payment of any benefits under this Policy based on a Change is subject to the Policyholder's [written] acceptance of any necessary adjustment to the premium.

Part 7. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate **{Option:}** 11:59 PM current [Eastern] Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.

2. The Premium Due Date next following receipt by us of written notice from the Policyholder that this Policy is to be terminated.

3. The end of any Policy Term, following {Option, 30 standard :} [30] [60 [90] [120] [180] days prior written notice to the Policyholder of termination.

4. The Premium Due Date following {Option, 30 standard :} [30] [60] [90] [120] [180] days prior written notice to the Policyholder that we are planning to terminate this Policy because: {Options:}

   [a.] [there are fewer than {Option, 50 standard :} [25] [50] {Option, Covered Units standard :} [Covered Units] [Participants];or]

   [b.] [the number of {Option, Covered Units standard :} Covered Units] [Participants] has changed by {Option, 10% standard :} [10%] [15%] [20%] [25%];or]

   [c.] [we have refused to accept a Material Change;or]

   [d.] [the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change; or].

   [e.] [Termination of the Covered Underlying Plan(s); or]

   [f.] [Cancellation of the administrative agreement between the Policyholder and the Claims Administrator, unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing].

{Option, use without prior notice requirement :}
[5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.]

{Option, use without prior notice requirement :}
[6. The date of cancellation of the administrative agreement between the Policyholder and the Claims Administrator, [unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection [in writing].]

{Option :}
[7. On any date mutually agreed to by the Policyholder and us.]

{Option:}
If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates.

{Option:}
If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates. {Option:} However, if this Policy terminates prior to the end of the Policy Term, the Aggregate Benefit, if any, will not be pro-rated and the full Minimum Aggregate Deductible will still apply to Eligible Claims Expenses [Incurred] [and] [or] [actually] [Paid] {Option:} [prior to] [by 11:59 PM current [Eastern] Time on the date this Policy terminates.

{Option :}
If this Policy terminates prior to the end of the current Policy Term:

1. The Aggregate Benefit, if any, will not be payable; and

2. The Covered Claims Basis shown in the Specific Benefit Schedule will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates.

B. RENEWAL

Unless terminated during or prior to the end of current Policy Term, this Policy may be renewed at the end of any Policy Term. At renewal we reserve the right to revise the terms and conditions that apply to the Policy including the rates, Deductibles, and the terms and conditions of this Policy by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Claim Information prior to the beginning of the subsequent Policy Term; and
2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

Part 8. PREMIUMS

A. AMOUNT OF PREMIUMS

Premium is calculated based upon the number of Covered Units reported in any given Policy Month. The number of Covered Units for each Policy Month will be determined in accordance with the definition of Covered Unit. The estimated number of Covered Units for the first Policy Month shown in the {Option :} [Specific Benefit Schedule] {Option :} [and] [Aggregate Benefit Schedule] is based on the estimated initial enrollment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of [Participants] [Covered Units] changes by more than {Option:} [10%] [15%] [20%] [25%] {Option :} [from the number reported at the end of the previous Policy Month] {Option; standard :} [on the Effective Date of this Policy or the number on the date of the last Policy Anniversary, whichever is the later date].

{Option:}
[2.] [Retroactively to the beginning of the Policy Term, if we determine that claim payments are not being made in accordance with the terms and conditions of the Covered

Underlying Plan(s).]

{Option, version 1:}
[3.] On the date of any Material Change approved by us.

{Option, version 2:}
[3.] [On the Premium Due Date following the] date we approve any Material Change, if such Change is expected to change Eligible Claims Expenses actually Paid by the Policy by more than {Option:} [10%] [15%] [20%] [25%].]

{Option :}
[4.] [The date of an administrative agreement between the Policyholder and a new Claims Administrator is effective provided we have consented to the Policyholder's selection [in writing].]

{Option :}
[5.] [On any Premium Due Date, if any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of Participants, or a change in law or legislation changes the nature of the risk assumed under this Policy by more than {Option:} [10%] [15%] [20%] [25%].]

{Option, standard included unless a rate guarantee period or rate cap applies :}
[6.] [On any Policy Anniversary.]

{Option :}
[7.] [At the end of any Policy Term.]

We will give the Policyholder {Option, 30 standard :} [30] [45] [60] [90] [120] [180] days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the applicable Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of {Option, 31 standard :} [31] [45] [60] [90] days will be allowed for the payment of each premium after the first premium. Should a premium which is otherwise due not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM current [Eastern] Time, without further notice to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Paid by the Policyholder prior to 11:59 PM current [Eastern] Time on last day of the Policy Month for which premiums were last paid.

{Option :}
[E. PREMIUM ADJUSTMENTS

Any retrospective request by the Policyholder for a premium adjustment due to a misstatement of Covered Units must be made within {Options :} [30] [45] [60] [90] [120] [180] days following the end of the current Policy Term. Such requests must be in writing and accompanied by evidence that an adjustment should be made. Any premium adjustment is limited to the number of Policy Months in the prior Policy Term.]

Part 9. GENERAL PROVISIONS

A. HOLD HARMLESS

1. The Policyholder agrees to hold us harmless from any legal expenses incurred or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or judgments were not incurred as a result of our [intentional] negligence or intentional wrongful acts.

   If we are notified that we have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s) we will give the Policyholder written notice of the dispute within {Option :} [a reasonable time] [15] [30] [45] [60] [days] . We will make all probative material available to the Policyholder upon written request from the Policyholder. We will cooperate with the Policyholder in matters pertaining to the dispute. However, such cooperation with the Policyholder will not waive our right to solely defend or settle any such action in any manner we deem prudent.

2. We agree to hold the Policyholder harmless from any legal expenses incurred or judgments(s) awarded arising out of any breach of this Policy by us arising out of our negligence or wrongful acts to the extent such legal expenses or judgments(s) were not incurred as a result of the Policyholder's intentional negligence or intentional wrongful acts.

   If the Policyholder is notified that they have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), the Policyholder will give us written notice of the dispute within {Option :} [a reasonable time] [15] [30] [45] [60] [days]. The Policyholder will make all probative material available to us upon our written request. The Policyholder will cooperate with us in matters pertaining to the dispute. However, such cooperation will not waive the Policyholder's right to solely defend or settle any such action in any manner they deem prudent.

B. TAXES

The Policyholder agrees to hold us harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state premium tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state premium tax liability including any interest, penalty and costs incurred by us as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be our responsibility.

C. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Claims Administrator and on which it reasonably appears a benefit will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

D. POLICY NON-PARTICIPATING

This Policy is non-participating and does not share in our surplus earnings.

E. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for the non-payment of premium.

F. RECOVERY

The Policyholder must prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder and must account to us for any amounts recovered.

{Option – subrogation; not used with right of recovery and subrogation and/or right of recovery :}
[However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we will subrogate the recovery of such claims on behalf of the Policyholder.]

{Optional - right of recovery; not used with subrogation or subrogation and/or right of recovery :}
[However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we will require the Policyholder to assign us the right to prosecute such claims on behalf of the Policyholder.]

{Option, standard - subrogation and/or right of recovery; not used with subrogation or right of recovery :}
[At that time we may, at our option, bring legal action to recover from the third party the amount of any benefits we paid to the Policyholder in connection with the payment of Eligible Claims Expenses caused by the third party's negligence or wrong-doing. The Policyholder will be required to provide us with any legal instruments, documents, or a paper we may need to exercise our right to recover and the Policyholder is prohibited from doing anything to prejudice our right to recover payments from the third party.]

G. REIMBURSEMENT

In the event that the Policyholder recovers from a third party with respect to any Eligible Claims Expenses for which benefits were paid under this Policy, the Policyholder must repay us. The full amount of any and all such funds recovered must be returned to us first before any Deductible under this Policy will be satisfied. No part of any Eligible Claims Expense which is [actually] Paid by the Policyholder and for which the Policyholder has been reimbursed by a third party may be used to meet any Deductible under this Policy. This provision will survive the termination of this Policy.

H. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

{Option :}
[I.] ARBITRATION

{Option, binding :}
In the event of a dispute between the parties to this Policy upon which an amicable understanding cannot be reached, either party has the right to refer the dispute to binding arbitration.

The Court of Arbitrators, which is to be held in the city where the home office of the Policyholder is located, will consist of three arbitrators familiar with the Covered Underlying Plan(s) and/or stop loss insurance policies. One of the arbitrators will be appointed by the Policyholder, one by us, and the first two appointees prior to the beginning of the arbitration will select the third.

Should the two arbitrators be unable to agree upon the choice of a third, the appointment will be left to the President or any Vice President of the American Arbitration Association. The arbitrators are empowered to decide all questions or issues and will be free to reach their decision by application of principles of equity and customary practice of the Insurance and reinsurance industry rather than by strict application of all rules of evidence and law. They will decide by a majority of votes and there will be no right of appeal from their written decision. The cost of arbitration, including the fees of the arbitrators, will be borne by the losing party unless the arbitrators decide otherwise.

{Option, non binding :}
In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in [Allegheny County, Pittsburgh, PA].

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and

2. Bear the expenses of the third arbitrator equally.

Part 10. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator must:

1. Keep appropriate records regarding administration of the Covered Underlying Plans; and

2. Allow us to review and copy, during normal business hours, all records affecting our liability under this Policy; and

3. Submit {Option :} [or allow access to] all proofs, reports, and supporting documents requested by us, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator on a timely basis.

Clerical error, whether by the Policyholder or by us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

B. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy prior to or after processing a claim for benefits. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

[C.] UNDERWRITING INFORMATION

We rely on the underwriting information and Claim Information [provided] [Disclosed] by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and

2. To accept a person as a Participant; and

3. [The Claim Information provided] to renew this Policy.

Should additional information become Known after one of these events that affects the rates, deductibles, or the terms and conditions of this Policy, we reserve the right to revise the rates, deductibles, and the terms and conditions of this Policy retroactive to the effective date of the current Policy Term by providing written notice to the Policyholder.

Part 11. LIABILITY AND INDEMNIFICATION

A. LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

B. INDEMNIFICATION

To the extent we suffer any liability, loss or expense due to a misstatement or failure to provide any Known o requested information, or failure to provide any additional information requested by us on a Participant or a person for whom we have requested [Disclosure [or] Claim Information, the Policyholder agrees to indemnify us up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

To the extent the Policyholder suffers any liability, loss or expense due to our breach of this Policy or due to our negligence or wrongful acts, we agree to indemnify the Policyholder up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

Part 12. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and

2. The Application; and

3. Submitted Claim Information; and

{Option :}
[4.] [Disclosure Statements and Disclosure Forms; and]

[5.] Attached documents necessary for the administration of this Policy.

This Policy or the Policyholder's coverage under this Policy may be amended at any time by mutual consent between the parties. No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Designated TPA has authority to change this Policy or to waive any of its provisions.

Part 13. INCONTESTABLE CLAUSE

In the absence of fraud, any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder effecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

Part 14. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after written proof of loss has been furnished to us. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

Part 15. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator will not impose upon us any liability other than the liability defined in this Policy.

Part 16. ASSIGNMENT

{Option :}
No assignment of interest under this Policy will be binding upon us unless and until the original or a duplicate is on file with us. We do not assume any responsibility for the validity of an assignment.

{Option :}
The Policyholder’s rights and benefits under this Policy cannot be assigned.

Part 17. DEFINITIONS

AFFILIATE means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by amendment to coverage under this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

AGENT means the Policyholder’s representative, including but not limited to, the agent, producer or broker of record, or Claims Administrator.

{Option :}
[ANNUAL AGGREGATE DEDUCTIBLE means the dollar amount of Aggregate Eligible Claims Expenses that must be actually Paid by the Policyholder during any Policy Term for all Covered Units before an Aggregate Benefits becomes payable to the Policyholder.

{Option :} [This amount cannot be finally determined until the end of the current Policy Term; that

calculation is based on the formula shown in the Aggregate Benefit Schedule.]

{Option :}
[AGGREGATE ATTACHMENT POINT (Corridor) means the percentage of anticipated Aggregate Eligible Claims Expenses which the Policyholder must pay before an Aggregate Benefit becomes payable to the Policyholder. {Option:} [The Aggregate Attachment Point (Corridor) shown in the Aggregate Benefit Schedule, is used to determine the Aggregate Factor for the Policy Term.]

{Option :}
[AGGREGATE BENEFIT means a benefit that is paid when Aggregate Eligible Claims Expenses actually Paid by the Policyholder on all Covered Units in a Policy Term exceed the Annual Aggregate Deductible shown in the Aggregate Benefit Schedule.]

{Option:}
[AGGREGATE ELIGIBLE CLAIMS EXPENSE means Eligible Claims Expenses that are actually Paid by the Policyholder during the current Policy Term used to calculate the Aggregate Benefit for that Policy Term. This term does not include any Eligible Claims Expenses used to satisfy a Specific Deductible or an Excluded Claim Expense.

Option:}
[MAXIMUM AGGREGATE ELIGIBLE CLAIMS EXPENSE means the maximum dollar amount of Eligible Claims Expenses that are actually Paid by the Policyholder for a [Participant][Family] [Covered Unit] during the current Policy Term which can be used either to satisfy the Annual Aggregate Deductibles or included in the calculation of the Aggregate Benefit for that Policy Term. The Maximum Aggregate Claims Expense is shown in the Aggregate Benefit Schedule.]

{Option without corridor included in the Monthly Aggregate Factor:}
[MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month in [the Policy Term][the period from * through *], A times B, where:

A = The Aggregate Factor per Covered Unit

B = The number of Covered Units as reported by the Policyholder [or the Policyholder's Claims Administrator at the start of that Policy Month.]

{Option, with corridor included:}
[MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month in [the Policy Term][the period from * through *], A times B times C, where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule

B = The number of Covered Units reported by the Policyholder [or the Policyholder's Claims Administrator at the start of that Policy Month.]

C = The Aggregate Attachment Point (Corridor)

{Option :}
[AGGREGATE FACTOR means the dollar amount shown in the Aggregate Benefit Schedule.]

{Option :}
[AGGREGATE PAYABLE PERCENTAGE means the percentage of the Aggregate Benefit, otherwise payable to the Policyholder that will be paid when Aggregate Eligible Claims Expenses, which are actually Paid by the Policyholder in the current Policy Term, exceed the Aggregate Attachment Point (Corridor).]

APPLICANT means the entity; that has contracted with us to provide Stop Loss coverage.

APPLICATION means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

CATASTROPHIC CLAIM means any Known claim for a Covered Claim Expense Incurred, or expected to be Incurred by a Participant that may reasonably be assumed will exceed 50% {Option :} [of the Specific Deductible] [or] {Option :} [10%] [25%] [50%] [of the] [Annual Aggregate Deductible in the current or next Policy Term.

{Option:}
[CLAIM INFORMATION means to provide Complete Details following a Diligent Review of the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended {Option :} [30] [45] [60] [90] [120] [180] [270] [365] [days] prior to the beginning of any Policy Term or prior to a Material Change, Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.]

COMPLETE DETAILS means detailed information including, but not limited to the Participant's name and social security number, date of birth, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the Policyholder's or the Policyholder's Claims Administrators control), and provider name on any Participant covered by, or eligible for coverage, under a Covered Underlying Plan. For purposes of privacy, a unique identifier may be used to identify the Participant in lieu of the person's name, social security number and date of birth.

COVERED CLAIMS BASIS means the time period shown in the {Option :} [Specific Benefit Schedule] {Option :} [and the] [Aggregate Benefit Schedule] {Option; standard incurred & paid :} [during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be actually Paid by the Policyholder in any Policy Term. The Covered Claim Basis is shown in the {Option :} [Specific Benefit Schedule] {Option :} [and the Aggregate Benefit Schedule].

COVERED SERVICE or SERVICES means a service, supply or treatment for which the Participant has incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s). This does not include any service excluded under Special Risk Limitations.

COVERED UNDERLYING PLAN(S) means the plans which are identified in this Policy. This does not include any plan excluded under Special Risk Limitations.

COVERED UNIT or COVERED UNIT(S) means a group of one or more Participants composed of one or more of the following types of Covered Units:

1. Single - a single employee, associate or member); or

2. Single Plus One - a single employee, associate or member and one eligible dependent; or

3. Single Plus Two – a single employee, associate or member and two eligible dependents; or

4. Family - the family of an employee, associate or member); or

5. Composite - the employee, associate or member and all members of his or her family.

The number of Covered Units is used to calculate the premium due each month. The estimated number and type of Covered Units for the first Policy Month of the current Policy Term is shown under Number of Covered Units in the {Option :} [Specific Benefit Schedule] {Option :} [and the] [Aggregate Benefit Schedule].

DEDUCTIBLE(S) means the Specific Deductible, Alternative Specific Deductible, or Aggregate Deductible, as shown in the Specific Benefit Schedule, the Aggregate Benefit Schedule or the Special Risk Limitation Rider.

CLAIMS ADMINISTRATOR means the third party administrator designated by the Policyholder and approved by us. The Claims Administrator is shown in the Declaration Page.

DILIGENT REVIEW means a complete review by the Policyholder or Policyholder's Claims Administrator of the Covered Underlying Plan prior to the beginning of any Policy Term for Known potential Large Claims. The potential for a Large Claim is Known if prior to the beginning of any Policy Term or prior to a Material Change a reasonable person could assume the Policyholder or the Policyholder's Claims Administrator has actual information about such claim.

{Option :}
[DISCLOSURE OR DISCLOSED means to provide Complete Details and any other documentation requested following a Diligent Review including but not limited to census information and Claim Information prior to the beginning of any Policy Term or prior to a Material Change.]

{Option :}
[DISCLOSURE FORM OR DISCLOSURE STATEMENT means the document signed by the Policyholder following a Diligent Review that provides information, upon which we will rely, in part, to issue the Policy.]

{Option :}
[DOMESTIC CLAIMS mean a claim for a Covered Service received by a Participant at a facility provided by the Policyholder or an Affiliate.

EFFECTIVE DATE means the date shown on the cover page of this Policy.

ELIGIBLE CLAIMS EXPENSE means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been actually Paid by the Policyholder in accordance with the terms of the Covered Underlying Plan(s). This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan;,or

2. Excluded under the terms of the Covered Underlying Plan; or

2. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations.

{Option :} [Eligible Claims Expenses may include any applicable surcharges assessed by state and/or federal rules, laws, or regulations but do not include any additional surcharges or penalties imposed by such rules, laws or regulations.]

This term does not include any Excluded Claims Expenses in Special Risk Limitations on the Declaration Page attached to this Policy.

{Option :}
[EXCLUDED CLAIMS EXPENSES means expenses which are Incurred by a Participant for services, supplies and treatment for, or related to, the condition, or resulting complications, of an injury or sickness described in Special Risk Limitations.]

{Option :}
FAMILY means an employee, associate or member of the Policyholder, and the eligible dependents of such person who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

INCURRED means the date a Participant receives a service, supply or treatment for an Eligible Claims Expense.

{Option :}
[ALTERNATE SPECIFIC DEDUCTIBLE means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain [Participants] [Families] identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such [Participant] [Family].]

KNOWN means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had knowledge of prior to a request for [Disclosure] [or] Claim Information or prior to a Material Change.

MATERIAL CHANGE or CHANGE means an action by the Policyholder that may have an economic impact on our liability under this Policy. Material Changes include, but are not limited to, the following:

1. Changes in:

    a. The information [Disclosed or] submitted by the Policyholder upon which our assessment of risk was based; or
    b. The Covered Underlying Plan(s); or
    c. The Claims Administrator.

2. An increase or decrease of the number of [Participants] [Covered Units] by more than [10] [15] [20] [25] % {Option :} in any Policy Month {Option; standard :} [from the Effective Date of this Policy or the date of the last Policy Anniversary, whichever is the later date].

3. A merger, acquisition, divestiture or similar transaction involving the Policyholder.

4. A bankruptcy proceeding involving the Policyholder or an Affiliate.

5. Any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of Participants, or a change in law or legislation changes the nature of the risk assumed by us under this Policy

This term does not include a change in the Covered Underlying Plan required by state or federal law.

{Option :}
[MAXIMUM AGGREGATE BENEFIT means the maximum dollar amount we will pay the Policyholder for the Aggregate Benefit in the current Policy Term. The Maximum Aggregate Benefit is shown in the Aggregate Benefit Schedule.]

{Option :}
[MAXIMUM SPECIFIC BENEFIT means the maximum dollar amount we will pay the Policyholder per [Participant] [Family] for the Specific Benefit {Options :} [in any Policy Term] {Option :} [or] [during that Participant's lifetime] [while all members of the Family are living]. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.]

{Option :}
[MINIMUM AGGREGATE DEDUCTIBLE means A multiplied by B, where:

A = The [estimated] number of Covered Units shown on the census submitted by the Policyholder, which we used to determine the Premium for the first month of the [initial] [current] Policy term

B = The number of months applicable to [the Paid period for] [the] [initial] [current] [that] Policy Term].

{Option :} [Times {Options :} [80] [85] [90] [95]%.]

{Option :}
[MINIMUM AGGREGATE DEDUCTIBLE means the dollar amount shown in the Aggregate Benefit Schedule for the current Policy Term.]

PAID means the date:

1. Eligible Claims Expenses have been adjudicated and approved by the Policyholder or the Policyholder's Claims Administrator; and

2. A check or draft for remuneration has been issued and deposited in the U.S. Mail (or other similar conveyance), or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by to the payee electronically or in person; and

3. Sufficient funds are on deposit the date the check or draft is issued to permit the check or draft to be honored; or a sufficient line of credit exists to honor the check, draft or transaction.

A claim will not be considered actually Paid until all of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason will not be considered actually Paid.

For purposes of this definition, "payee" means a Participant that received the Covered Service or the health care provider that provided the Covered Service to the Participant.

PARTICIPANT or PARTICIPANTS means a person who is an employee, associate or member of the Policyholder or Affiliate, and the dependents of such persons who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

POLICY means this contract between the Policyholder and us with respect to Stop Loss Insurance.

POLICY ANNIVERSARY means each anniversary of the Effective Date of this Policy, unless changed by agreement between the Policyholder and us.

POLICY MONTH means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of this Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY TERM means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the effective date of the policy to the date of the first Policy Anniversary.

2. A current or renewal Policy Term is the period of time either from the effective date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy term will begin on the Policy Anniversary. The initial Policy Term will begin on the Effective Date of this Policy.

POLICYHOLDER means the entity shown on the cover page of this Policy.

PREMIUM DUE DATE means the Effective Date of this Policy and the first day of each following Policy Month.

LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that

the Policyholder or the Policyholder's Claims Administrator reasonably assumes will result in a significant medical expense in the current or next Policy Term.

SPECIAL RISK LIMITATION means any modification of the terms or conditions of this Policy.

[SPECIFIC BENEFIT means the benefit paid when Eligible Claims Expenses actually Paid by the Policyholder for a [Participant] [Family] in any Policy Term exceed the Specific Deductible.]

{Option :}
[SPECIFIC DEDUCTIBLE means the dollar amount which must be satisfied prior to any Specific Benefit becoming payable. The Specific Deductible is shown in the Specific Benefit Schedule.]

{Option :}
[SPECIFIC PAYABLE PERCENTAGE means the percentage of the Specific Benefit, otherwise payable to the Policyholder, that will be paid when Eligible Claims Expenses, which are [actually] Paid by the Policyholder for a Participant, exceed the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.]

STOP LOSS INSURANCE means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are [actually] Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

UNDERLYING PLAN(S) means the employee benefit plans of the Policyholder which provide the benefits identified in the {Option:} Specific Benefit Schedule {Option:} [or the] [Aggregate Benefit Schedule] to the Policyholder's or an Affiliate's employees, associates or members and their dependents. This Policy insures the Policyholder for excess losses through the employee benefit plans identified in this Policy as a Covered Underlying Plan. This term does not include any employee benefit plan of the Policyholder that is not identified as a Covered Underlying Plan in this Policy.

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

AGGREGATE ADVANCE FUNDING RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed:

Aggregate Advance Funding is available subject to the following:

1. At the end of the current Policy Term the sum of the Monthly Aggregate Deductible {Adapt to case – Covered Unit standard; use Covered Family Unit if family deductible applies :} per [Participant] [Covered Family Unit] must exceed the Minimum Aggregate Attachment Point for the same period.

2. Claims submitted for an advance must be fully processed by the Claims Administrator and ready for payment according to the terms of the Benefit Plan within the current Policy Term.

3. The account funded by the Policyholder used by the Claims Administrator to pay claims through the Benefit Plan must contain funds equal to {Adapt to case:} [50%} [60%] [70%] [[80%] [90%] [100%] of the sum of the Monthly Aggregate Attachment Point at the end of the current Policy Term.

4. Each request for an advance must be equal to or greater than {Adapt to case - $1,000 standard :} $[500] [1,000] [2,500] [5,000].

5. We must receive the request for an advance no later than {Adapt to case – 30 standard :} [15] [30] [45] [60] [90] [120] days after the end of the current Policy Term. Any request received after this period is not eligible for Aggregate Advance Funding.

6. At the end of the Policy Term, or Run-out Period shown in the Schedule, if later, any advance by us that exceeds the amount payable under the Aggregate Benefit must be repaid within {Adapt to case - 10 standard} [5] [10] [15] [31] days of written notice from us . We will provide such notice to the Policyholder within 31 days of the end of the current Policy Term or Run-out Period, if later or as soon as reasonably possible.

{Option:}
[7.] [Premiums must be paid prior to the end of the Grace Period. Should a premium which is otherwise due not be paid prior to the end of the Grace Period:

   a. The Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid; and

   b. The Policyholder must reimburse us for the any funds advanced by us during the Grace Period within {Option - five standard :} [5] [10] [15] working days

All other terms and provisions of the Policy will apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

AGGREGATING SPECIFIC LOSS FUND RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph A is replaced with:

SPECIFIC BENEFIT WITH AGGREGATING SPECIFIC LOSS FUND

We will pay the Policyholder the following Specific Benefits once the Aggregating Specific Loss Fund is satisfied in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregating Specific Loss Fund is satisfied when the sum of the Specific Benefit amounts otherwise payable exceed the amount of the Aggregating Specific Loss Fund.

When the Aggregating Specific Loss Fund is satisfied we will:

1. Pay the amount of all Specific Benefits otherwise due, which in total exceed the amount of the Aggregating Specific Loss Fund; and

2. Begin to pay any additional Specific Benefits as they become due, subject to the terms and conditions of this Policy.

Any additional Specific Benefit payable with respect to a Participant following satisfaction of the Aggregating Specific Loss Fund will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Participant minus (A plus B), where:

A = The Specific Deductible for the Participant

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Times the Specific Payable Percentage

The amount of the Aggregating Specific Loss Fund for the current Policy Term is: $[*]

In no event will the Specific Benefit paid by us or applied toward satisfaction of the Aggregating Specific Loss Fund with respect to Eligible Claims Expenses which are Incurred by any one [Participant] [Family] exceed the Maximum Specific Benefit.

{Option – Excluded Claims Expenses :}
[The Specific Benefit does not include any amount [actually] Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

AGGREGATE TERMINAL LIABILITY RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph B is amended by the addition of the following:

AGGREGATE TERMINAL LIABILITY

If the Policyholder notifies us of a decision to elect the Aggregate Terminal Liability {Option :} [30 days] prior to the end of the current Policy Term, the Policy will be amended as follows to cover run-out claims from the Aggregate Benefit:

The Incurred and Paid period shown in Covered Claims Basis in the Aggregate Benefit Schedule is amended {Option, standard :} [to read] {Option, used if applicable to a location :} [by the addition of]:

> Eligible Claims Expenses {Option, used if limited to location :} [with respect to {Options :} [class[[location] [affiliate]], except those to which a Special Risk Limitation applies, incurred during the current Policy Term and actually Paid during the current Policy Term or within {Options:} [three] [six] months immediately thereafter.

To fund Aggregate Terminal Liability the Monthly Aggregate Deductible for each of the last three months of the Policy Term will be increased by the Aggregate Terminal Liability Factor {Option, used if limited to location :} [with respect to {Options :} [class[[location] [affiliate]]. The sum of this amount is then added to the Annual Aggregate Attachment Point shown in the Aggregate Benefit Schedule to determine the total Aggregate Terminal Liability funding level.

The Aggregate Terminal Liability Factor is {Options; 115% is standard :} [110] [115] [120] [125]%

The Covered Claim Basis for the Aggregate Benefit does not include any amount actually Paid by the Policyholder:

1. Excluded or Limited by this Policy; or

2. Subject to a Special Risk Limitation; or

3. For Covered Expenses incurred by a Participant recovered by the Policyholder through any recovery provision of the Covered Underlying Plan; or

4. More than [Options :} [three] [six] months immediately following the end of the current Policy Term.

The Policyholder's election of the Aggregate Terminal Liability Provision will only become effective if each of the following conditions is met:

{Option, standard used if applicable to entire policy :}
[1.] [The Policyholder must terminate this Policy in writing prior to the end of the current Policy Term {Option, standard :} [and return to a fully insured health insurance program].]

{Option, used if limited to location :}

[1.] [Coverage for {Options :} [class [[location] [affiliate]] under the Policy must be terminated by the Policyholder in writing prior to the end of the current Policy Term {Option, standard :} [and that {Options :} [class [[location] [affiliate]] must return to a fully insured health insurance program].]

[2.] The Policyholder must notify us of their decision and elect Aggregate Terminal Liability {Option, used if limited to location :} [with respect to {Options :} [class [[location] [affiliate]] {Option :} [30 days] prior to the end of the current Policy Term.

[3.] The {Option, used if limited to location :} [entire] Aggregate Benefit must remain in effect through the end of the Policy Term.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

FAMILY AGGREGATING SPECIFIC LOSS FUND RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph A is replaced with:

FAMILY SPECIFIC BENEFIT WITH FAMILY AGGREGATING SPECIFIC LOSS FUND

We will pay the Policyholder the following Family Specific Benefit once the Family Aggregating Specific Loss Fund is satisfied in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Family Aggregating Specific Loss Fund is satisfied when the sum of the Family Specific Benefit amounts otherwise payable exceed the amount of the Family Aggregating Specific Loss Fund.

When the Family Aggregating Specific Loss Fund is satisfied we will:

1. Pay the amount of all Family Specific Benefits otherwise due, which in total exceed the amount of the Family Aggregating Specific Loss Fund; and

2. Begin to pay any additional Family Specific Benefits as they become due subject to the terms and conditions of this Policy.

Any additional Family Specific Benefit payable following satisfaction of the Family Aggregating Specific Loss Fund will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Family minus (A plus B)), where:

A = The Specific Deductible for the Family.

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant who is a member of the family later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Times the Specific Payable Percentage

The amount of the Family Aggregating Specific Loss Fund for the current Policy Term is: $[*]

In no event will the Family Specific Benefit paid by us or applied toward satisfaction of the Family Aggregating Specific Loss Fund exceed the Maximum Specific Benefit.

{Option – Excluded Claims Expenses :}
[The Specific Benefit does not include any amount [actually] Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company
By
President

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1-800-328-5433

FAMILY SPECIFIC ADVANCE FUNDING RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed:

The only Covered Expenses eligible for Specific Advance Funding those that exceed the sum of the Specific Deductible per Family, {Option :} [or the Alternate Specific Deductible shown in the Special Risk Limitation Rider per Family.

Specific Advance Funding is available if all of the following conditions have been met:

1. The Specific Deductible per Family {Option :}[, or the Alternate Specific Deductible per Family has been met.

2. Claims submitted for an advance must be fully processed by the Claims Administrator and ready for payment according to the terms of the Benefit Plan within the current Policy Term.

3. Each request for an advance must be equal to or greater than {Option - $1,000 standard :} $[500] [1,000] [2,500] [5,000].

4. Claims must be Incurred during the current Policy Term and we must receive the request for an advance no later than {Option – 30 standard :} [15] [30] [45] [60] [90] [120] days after the end of the current Policy Term. Any request received after this period is not eligible for Advance Specific Funding.

5. The Covered Expense for which funds were advanced must be actually Paid within {Option - five standard :} [5] [10] [15] working days after receiving the advance for such expense. We will consider any Covered Expense actually Paid within this time period to have been Paid within the current Policy Term, even if such payment occurs after the end of the current Policy Term, or Run-out Period shown in the Specific Benefit Schedule, if later. If the Policyholder does not pay the Covered Expense within this time period, the advance must be refunded to us.

6. Any funds advanced by us not used to pay a Covered Expense due to any type of discounting must be refunded to us within {Option - five standard:} [5] [10] [15] working days.

{Option:}

[7.] [Premiums must be paid prior to the end of the Grace Period. Should a premium which is otherwise due not be paid prior to the end of the Grace Period:

   a. The Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid; and

   b. The Policyholder must reimburse us for the any funds advanced by us during the Grace Period within {Option - five standard :} [5] [10] [15] working days.

All other terms and provisions of the Policy will apply.

HM Life Insurance Company
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President

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1-800-328-5433

BRIDGE RENEWAL RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed:

1. That Covered Claims Basis in the Specific Benefit Schedule is amended by the addition of:

Bridge Renewal

During the current Policy Term, any Eligible Claim Expense Incurred prior to the end of that term but actually Paid after the current Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the renewal Policy Term; as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the Incurred Period and Paid during the Run-out Period for the renewal Policy Term will be considered an Eligible Claim Expense for purposes of that renewal Policy Term.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the renewal Incurred Period but actually paid after the renewal Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the subsequent Policy Term as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

As used above:

"Run-out period" is the [three] [six] month period immediately following the end of the current or any subsequent Policy Term.

"Incurred Period" is the period from [original Covered Claims basis incurred date] to the end of the current Policy Term.

All other terms and provisions of the Policy will continue to apply.

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1-800-328-5433

MONTHLY AGGREGATE ACCOMMODATION RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph B is replaced with:

AGGREGATE BENEFIT WITH MONTHLY AGGREGATE ACCOMMODATION

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are [actually] Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B plus C), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

Except as provided in the Monthly Aggregate Accommodation Benefit, we will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

Monthly Aggregate Accommodation:

[Except for the final month of the current Policy Term,] we will make advance payments to the Policyholder reflecting the pro-rata share of the projected Aggregate Benefit attributable to the Policy Months which have elapsed during this Policy Term.

The amount of each such Monthly Aggregate Accommodation payment will be equal to the amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder during the Policy Months which have elapsed during this Policy Term, minus (A plus B plus C plus D), where:

A = The amount of all Monthly Aggregate Accommodation Benefits already advanced to the Policyholder during this Policy Term.

B = The portion of the Annual Aggregate Deductible attributable to the Policy Months that have elapsed during this Policy Term equal to (1) or (2), whichever is greater, where:

(1) = The proportionate share of the Minimum Aggregate Annual Deductible

(2) = The sum of the Monthly Aggregate Annual Deductible for the Policy Months which have elapsed during this Policy Term.

C = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]. Note that this item of the calculation is not pro-rated.

D = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage,

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

The amount of the Aggregate Benefit, if any, due for the Policy Term cannot be finally determined until after the end of the Policy Term.

When the amount of the Aggregate Benefit due for the Policy Term is finally determined following the end of the Policy Term, we will pay to the Policyholder the amount, if any, which exceeds the amount already advanced as Monthly Aggregate Accommodation benefits. If the amounts already advanced as Monthly Aggregate Accommodation benefits exceed the amount of the Aggregate Benefit due for the Policy Term, the Policyholder must immediately reimburse us for the excess amount at the end of the current Policy Term.

{Option :} If this Policy terminates prior to the end of the Policy Term the Policyholder must immediately reimburse us for any amount already advanced as a Monthly Aggregate Accommodation benefit.

No interest will be charged on the amount of any Monthly Aggregate Accommodation benefits advanced to the Policyholder.

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MEDICAL TRAVEL RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that The Policy is amended by the addition of the following:

MEDICAL TRAVEL BENEFITS

We will reimburse the Policyholder for:

1. Eligible Claim Expenses incurred by a Participant for Covered Services received outside of the United States;

2. Medical Travel access fees, if such fees are covered through the Covered Underlying Plan;

3. Travel, lodging and meal expenses incurred by a Participant (and that Participant's parents or legal guardian(s) if the Participant is a minor or one companion if the Participant is not a minor) in connection with the Medical Travel, provided such expenses are covered through the Covered Underlying Plan up to [$500-$10,000] for travel, lodging and meal expenses incurred by the Participant (and the Participant's parents or legal guardian(s) if the Participant is a minor or one companion if the Participant is not a minor) in connection with the Medical Travel if the Medical Travel was arranged by a Medical Travel vendor approved by us; and

4. For any deductible or co-payment related to a Covered Service for Medical Travel for which the Participant has been reimbursed through the Covered Underlying Plan up to [$500-$5,000]; and

5. Up to [$100-$5,000] for Medical Travel access fees.

Provided all of the following requirements are satisfied:

1. The Covered Underlying Plan covers treatment received by a Participant outside of the United States;

2. The Participant's Medical Travel must be provided by and arranged through a vendor approved by us (the "Medical Travel Vendor").

3. You demonstrate that the:

    a. Covered Underlying Plan has paid for the Participant's Medical Travel and the Covered Services provided in connection with it; and

    b. Covered Services have been provided to the Participant.

4. The expenses resulting from the Covered Services provided in connection with the Medical Travel must be Eligible Claim Expenses.

[For the purpose of this provision only, the FOREIGN MEDICAL CARE exclusion is waived if all of the above requirements are satisfied; however, this exclusion will apply to any other claim for Covered services related to Medical Travel.]

[Medical Travel Benefits do not include coverage for any organ or tissue transplant received by a participant outside of the United States.]

As used herein Medical Travel means travel by a Participant outside of the United States to obtain medical treatment from a doctor, hospital or healthcare provider.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

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1-800-328-5433

RATE CAP RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed Changes in Premium Rates is amended by the addition of:

{Option, "*" indicates next number in sequence in Changes in Premium Rates :}

[*.] [At renewal] [On any Policy Anniversary] any increase in the Specific Premium Rate will be limited to {Option :} [40%] [45%] [50%] for the next Policy Term. If applicable this increase will apply to the Aggregating Specific Loss Fund Term [provided there are no Material Changes].

At renewal we will not apply any new Special Risk Limitation including but not limited to an Alternate Specific deductible or Excluded Claim Expense unless requested in writing by the Policyholder.

We reserve the right to revise the deductibles, and other terms and conditions of this Policy at the end of any Policy Term by providing written notice to the Policyholder.

All other terms and conditions of the Policy will continue to apply including but not limited to reapplication of the Specific Deductible [and Aggregate Deductible] in the next Policy Term.]

HM Life Insurance Company

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RATE GUARANTEE RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed Changes in Premium Rates is amended by the addition of:

{Option, "*" indicates next number in sequence in Changes in Premium Rates :}

[*.] Except as provided in 1, 2, 3 or {Option, included or excludes as sequence indicates :} [4] [5] above, we will not change the [Specific] [or] [Aggregate] Premium Rates during the Rate Guarantee Period shown in the Declaration Page. The Rate Guarantee Period is a successive monthly period beginning on the first day of the current Policy Term.

At renewal we will not apply any new Special Risk Limitation including but not limited to an Alternate Specific deductible or Excluded Claim Expense unless requested in writing by the Policyholder.

We reserve the right to revise the deductibles, and other terms and conditions of this Policy at the end of any Policy Term by providing written notice to the Policyholder.

All other terms and conditions of the Policy will continue to apply including but not limited to reapplication of the Specific Deductible [and Aggregate Deductible] in the next Policy Term.

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SPECIFIC ADVANCE FUNDING RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed:

The only Covered Expenses eligible for Specific Advance Funding those that exceed the sum of the Specific Deductible per Participant, [{Option :} [or the Alternate Specific Deductible shown in the Special Risk Limitation Rider per Participant.

Specific Advance Funding is available if all of the following conditions have been met:

1. The Specific Deductible per Participant {Option :}[, or the Alternate Specific Deductible per Participant has been met.

2. Claims submitted for an advance must be fully processed by the Claims Administrator and ready for payment according to the terms of the Benefit Plan within the current Policy Term.

3. Each request for an advance must be equal to or greater than {Option - $1,000 standard :} $[500] [1,000] [2,500] [5,000].

4. Claims must be Incurred during the current Policy Term and we must receive the request for an advance no later than {Option – 30 standard :} [15] [30] [45] [60] [90] [120] days after the end of the current Policy Term. Any request received after this period is not eligible for Advance Specific Funding.

5. The Covered Expense for which funds were advanced must be actually Paid within {Option - five standard :} [5] [10] [15] working days after receiving the advance for such expense. We will consider any Covered Expense actually Paid within this time period to have been Paid within the current Policy Term, even if such payment occurs after the end of the current Policy Term, or Run-out Period shown in the Specific Benefit Schedule, if later. If the Policyholder does not pay the Covered Expense within this time period, the advance must be refunded to us.

6. Any funds advanced by us not used to pay a Covered Expense due to any type of discounting must be refunded to us within {Option - five standard:} [5] [10] [15] working days.

{Option:}

[7.] [Premiums must be paid prior to the end of the Grace Period. Should a premium which is otherwise due not be paid prior to the end of the Grace Period:

   a. The Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid; and

   b. The Policyholder must reimburse us for the any funds advanced by us during the Grace Period within {Option - five standard :} [5] [10] [15] working days.

All other terms and provisions of the Policy will apply.

HM Life Insurance Company
By

President

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1-800-328-5433

AFFILIATE RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Affiliate in the Declaration Page is amended by the addition of the following Affiliates:

[Name]	[Covered Underlying Plan(s)]
[Specimen]	[Same as Policyholders]

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CONTINUOUS AGGREGATE ACCOMMODATION RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph B is replaced with:

AGGREGATE BENEFIT WITH CONTINUOUS AGGREGATE ACCOMMODATION

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B plus C, where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

Except as provided in Continuous Aggregate Accommodation, we will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

Continuous Aggregate Accommodation:

Except for the final month of the current Policy Term, we will make advance payments to the Policyholder of the projected Aggregate Benefit attributable to the Policy Months which have elapsed during the current Policy Term as they become due. The amount of each Continuous Aggregate Accommodation payment will equal the amount of the Aggregate Eligible Claims Expenses actually Paid by the Policyholder for all Covered Units from the effective date of the current Policy Term minus (A plus B plus C plus D), where:

A = Any Continuous Aggregate Accommodation payment previously paid the Policyholder during the current Policy Term and not repaid.

B = The portion of Annual Aggregate Deductible attributable to the Policy Months that have

elapsed during the current Policy Term equal to (1) or (2), whichever is greater, where:

(1) = The proportionate share of the Minimum Aggregate Annual Deductible for such months

(2) = The sum of the Monthly Aggregate Deductibles for the Policy Months which have elapsed during the current Policy Term.

C = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit] - this item of the calculation is not pro-rated.

D = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan

Times the Aggregate Payable Percentage

{Option :}
[Minus $[1,000 - $10,000]]

If the above calculation results in a negative number, the Policyholder must reimburse us for the difference within {Options :} [15] [30] [[31] [45] [60] days; failure by the Policyholder to do so within this time period will result in immediate termination of this rider without further notice to the Policyholder. Any such termination will not affect our right to offset any such difference from future payments.

{Option – excluded claims expenses :}
[The Covered Claims Basis for purposes of determining any Continuous Aggregate Accommodation payment does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses during the Policy Term.]

The amount of the Aggregate Benefit, if any, due for the Policy Term cannot be finally determined until after the end of the Policy Term.

When the amount of the Aggregate Benefit due for the Policy Term is finally determined following the end of the Policy Term, we will pay to the Policyholder the amount, if any, which exceeds the amounts already advanced as Continuous Aggregate Accommodation benefits. If the amounts already advanced as Continuous Aggregate Accommodation benefits exceed the amount of the Aggregate Benefit due for the Policy Term, the Policyholder must immediately reimburse us for the excess amount at the end of the current Policy Term.

{Option :} If this Policy terminates prior to the end of the Policy Term the Policyholder must immediately reimburse us for any amount already advanced as a Continuous Aggregate Accommodation benefit.

No interest will be charged on the amount of any Continuous Aggregate Accommodation benefits advanced to the Policyholder.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

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RENEWAL RIDER

To be attached to and made part of Policy [*] issued to [*] as Policyholder.

{Option, used on renewal if Part 1. Declaration page is replaced :}
Effective * it is herby agreed the following replaces part 1. Declaration Page for the Policy Term [Date] through [Date]:

Part 1. DECLARATION PAGE

{Option, used on renewal if Declaration Page is replaced :}
[This Declaration Page replaces the Declaration Page for Policy Number and Policyholder shown in A. Policy Information below the for the Policy Term **[(1)]** through **[(1)]** in its entirety.]

A. POLICY INFORMATION

1.	Policy Number	[Specimen]
2.	Policyholder	[Specimen]
3.	Current Policy Term	[Date] through [Date]
4.	Covered Underlying Plan(s)	[Policyholders] [See] [and] [Affiliates]
5.	Claims Administrator	[Specimen]

{Option – Specific Benefit Schedule :}
[A.] SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid prior to [Date].

{Option – initial 12/15; current Policy Term revised to 12/24 at renewal :}
[NOTE: If you renew this Policy the Covered Claims Basis for this Policy Term will be revised so that Eligible Claim Expenses include only such expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option - Bridge Renewal :}
During the current Policy Term, any Eligible Claim Expense Incurred prior to the end of that term but actually Paid after the current Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the renewal Policy Term; as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the Incurred Period and Paid during the Run-out Period for the renewal Policy Term will be considered an Eligible Claim Expense for purposes of that renewal Policy Term.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the renewal Incurred Period but actually paid after the renewal Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the subsequent Policy Term as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

As used above:

"Run-out period" is the [three] [six] month period immediately following the end of the current or any subsequent Policy Term.

"Incurred Period" is the period from [original Covered Claims basis incurred date] to the end of the current Policy Term.

2. Specific Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single Covered Unit	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Specific Deductible

{Option – standard offer :}
[Per Participant] $[*]

{Option :}
[Per Family] $[*]

5. Specific Payable Percentage (in excess of Specific Deductible) [*] **%**

{Option - Domestic Claims}
[6.] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] **%]**

[7.] Maximum Specific Benefit

{Option – standard offer :}
[Per Participant in excess of the Specific Deductible]

{Option :}
[Per Family in excess of the Specific Deductible]

{Option :}
[Per Policy Term] [None] [$ [*]]

{Option – standard offer :}
[Per Lifetime] [Unlimited] [$ [*]]

{Option – Aggregate Benefit Schedule :}
[B.] AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid from [Date] through [Date].

2. Aggregate Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Aggregate Payable Percentage (excess of Deductible): [*] %

{Option – may be removed if the corridor is a function of the monthly aggregate deductible calculation :}
[5.] [Aggregate Attachment Point (Corridor) [*] %]

{Option :}
[6.] [Minimum Aggregate Deductible $[*]]

[7.] Annual Aggregate Deductible

{Option – only used if a monthly aggregate deductible is not calculated :} [$[*]]

{Option, standard offer :}
[is equal to [A], [B] or [C] whichever is greater, where:

{Option - either A, B or both may be included:}
[A] [= The Monthly Aggregate Deductible Amount for the initial Policy Month times * the number of months in the current Policy Term]

{Option :}
[B] [= The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month [in] the current Policy Term]

{Option :}
[C] = [The Minimum Aggregate Deductible]

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the Aggregate Monthly Deductible Amounts have been calculated for each Policy Month of the Policy Term.

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the end of the Policy Term.

{Option – only used if a Monthly Aggregate Deductible is computed:}
[8.] [Monthly Aggregate Factor

{Option :}
[Per Single Covered Unit per Policy Month] $[*]

{Option :}
[Per Single Plus One Covered Unit per Policy Month] $[*]]

{Option :}
[Per Single Plus Two Covered Unit per Policy Month] $[*]]

{Option :}
[Per Family Covered Unit per Policy Month] $[*]]

{Option :}
[Per Composite Covered Unit per Policy Month] $[*]]]

{Option – used if aggregate claims expenses are limited :}
[9.] [Maximum Aggregate Eligible Claims Expense

{Option :}
[Per Single Covered Unit) $[*]

Option :}
[Per Single Plus One Covered Unit] $[*]]

[Per Single Plus Two Covered Unit] $[*]]

{Option :}
[Per Family Covered Unit] $[*]]

{Option :}
[Per Composite Covered Unit] $[*]]

{Option - domestic claims :}
[10] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] %]

[11.] Maximum Aggregate Benefit (in excess of the
Annual Aggregate Deductible) per Policy Term) $[*]

[C.] PREMIUM

{Option, standard :}
[Specific Premium per Month

Single Employee:	$[*]
Single Plus One	$[*]
Single Plus Two	$[*]
Family:	$[*]
Composite:	$[*]

{Option :}
[Minimum Annual Specific Premium: $ [*]]

[Initial][Specific] Rate Guarantee Period [*] Months]

{Option :}
[Aggregate Premium per Month Per Covered Unit: $ [*]]

[Minimum Annual Aggregate Premium: $ [*]]

The Specific Premium per Month [and the Aggregate Premium per Month per Covered Unit] only apply to the current Policy Term.

{Options, see variable summary; Special Risk Limitation used to:

- Describe an Alternate Specific deductible for a Covered Units or Covered Family Units.
- Describe instances where certain claim expenses are limited (capped) excluded for the period prior to the effective date of the policy, for a period of time following either the effective date or renewal date, for the entire time the contract is in effect, for a Plan Year, etc.; this may be tailored to apply to a Participant, employee class, Affiliate, limited to certain procedures, or a group of related procedures/ conditions.
- Describe instances where Participants, all employees of a certain class, an Affiliate, etc. are excluded from the policy; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude individual or groups of individual in certain situations (i.e., COBRA participants, Medicare participants, Medicaid participants, domestic partners, late enrollees, employees of an Affiliate, employees in a certain class, etc.); this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.

- Exclude or place an internal limit on certain types of claims expenses; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Apply a preexisting conditions limitation; this may be limited to a dollar amount, defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, a Participant, employee class, Affiliate, etc.
- Apply a separate run-in or run-out limit to a location, affiliate or employee class :}

[D.] SPECIAL RISK LIMITATIONS:

[None]

[Specific [See variable summary]]

[Aggregate [See variable summary]]

[E.] AFFILIATES

{Option, if no affiliates "none is used; if there are affiliates name(s) of affiliates are listed; if all affiliates have the same underlying plan as the policyholder "same as policyholders is listed – if different than policyholders plan's name /designation is entered :}
[None]

[Name]	[Covered Underlying Plan(s)]
[Specimen]	[Same as Policyholders]

{Option, used on renewal if entire policy is replaced :}
[It is herby agreed effective [*] that Policy [*] replaces Policy [*] for the Policy term beginning [*] and ending [*] in its entirety.]

All other terms and conditions of the Policy will continue to apply including but not limited to reapplication of the Specific Deductible [and Aggregate Deductible] in the next Policy Term.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

STEP-DOWN SPECIFIC DEDUCTIBLE RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Special Risk Limitations in the Declaration Page is amended by the addition of the following:

The Specific Deductible with respect to any one [Participant] [Family] will be reduced the Reduction Amount provided:

1. The Policyholder or the Policyholder's Claim's Administrator notifies us that a Participant has been diagnosed with kidney failure within {Options, five is standard :} [5] [10] [15] days of the placement of a fistula for future dialysis treatment; and

2. The dialysis treatment is managed by [Vendor].

OR

1. The Policyholder or the Policyholder's Claim's Administrator notifies us that a Participant has been diagnosed with cancer within {Options, five is standard :} [5] [10] [15] days of such diagnosis; and

2. That Participant will receive chemotherapy treatment; and

3. We were notified of the cancer diagnosis prior to the commencement of such Participant's chemotherapy treatment; and

4. The Participant's cancer treatment is managed by [Vendor].

Reduction Amount means the lesser of A or B, where:

A = The Specific Deductible per [Participant] [Family] for the current Policy Term times {Options; 10% is standard :} [5] [10] [15] [20]%; or

B = {Options; $10,000 is standard :} $[5,000] [10,000] [15,000] [20,000]

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

SPECIAL RISK LIMITATION RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Special Risk Limitations in the Declaration Page is amended by the addition of the following:

{Options, Special Risk Limitation used to:

- Describe an Alternate Specific deductible for a Participant or Covered Unit.
- Describe instances where certain claim expenses are limited (capped) excluded for the period prior to the effective date of the policy, for a period of time following either the effective date or renewal date, for the entire time the contract is in effect, for a Plan Year, etc.; this may be tailored to apply to a Participant, employee class, Affiliate, limited to certain procedures, or a group of related procedures.
- Describe instances where Participants, all employees of a certain class, an Affiliate, etc. are excluded from the policy; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude individual or groups of individual in certain situations (i.e., COBRA participants, Medicare participants, Medicaid participants, domestic partners, late enrollees, employees of an Affiliate, employees in a certain class, etc.); this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude or place an internal limit on certain types of claims expenses; these may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Apply a preexisting conditions limitation; this may be limited to a dollar amount, defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, a Participant, employee class, Affiliate, etc.
- Apply a separate run-in or run-out limit to a location, affiliate or employee class

[Specific]	[See Variable Summary]
[Aggregate]	[See Variable Summary]

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

SPECIFIC TERMINAL LIABILITY RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that Part 2 paragraph A is amended by the addition of the following provision:

SPECIFIC TERMINAL LIABILITY

If the Policyholder notifies us of a decision to elect Specific Terminal Liability {Option :} [30 days] prior to the end of the current Policy Term, the Policy will be amended as follows to cover run-out claims from the Specific Benefit:

The Incurred and Paid period shown in Covered Claims Basis in the Specific Benefit Schedule is amended {Option, standard :} [to read] {Option, used if applicable to a location :} [by the addition of]:

> Eligible Claims Expenses{Option, used if limited to location :} [with respect to {Options :} [class[[location] [affiliate]], except those to which a Special Risk Limitation applies, incurred during the current Policy Term and actually Paid during the current Policy Term or within {Options:} [three] [six] months immediately thereafter.

The Policyholder's election of the Specific Terminal Liability Provision will only become effective if each of the following conditions is met:

{Option, standard used if applicable to entire policy :}

[1.] [The Policyholder must terminate this Policy in writing prior to the end of the current Policy Term {Option, standard :} [and return to a fully insured health insurance program].]

{Option, used if limited to location :}

[1.] [Coverage for {Options :} [class [[location] [affiliate]] under the Policy must be terminated by the Policyholder in writing prior to the end of the current Policy Term {Option, standard :} [and that {Options :} [class [[location] [affiliate]] must return to a fully insured health insurance program].]

[2.] The Policyholder must notify us of their decision and elect Specific Terminal Liability {Option, used if limited to location :} [with respect to {Options :} [class [[location] [affiliate]] {Option :} [30 days] prior to the end of the current Policy Term.

[3.] The {Option, used if limited to location :} [entire] Specific Benefit must remains in effect through the end of the Policy Term.

The Covered Claims Basis for the Specific Benefit does not include any amount actually Paid by the Policyholder:

1. Excluded or Limited by this Policy; or

2. Subject to a Special Risk Limitation[; or

3. For Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s); or

4. More than [Options :} [three] [six] months immediately following the end of the current Policy Term.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

CANCER CLINICAL TRIAL RIDER

To be attached to and made part of Policy * issued to * as Policyholder. Effective * it is herby agreed that the definition of Eligible Claim Expenses is amended by the addition of:

This term includes the following items and services in connection with an approved cancer clinical trial:

1. Otherwise covered physician fees, laboratory expenses, and expenses associated with a hospitalization; and

2. Evaluation and treatment of the patient associated with the underlying disease; and

3. The cost of care consistent with the usual standards of care whenever a patient receives medical care associated with an approved cancer clinical trial; and

4. Care that would be covered by the Covered Underlying Plan if such items and services were provided other than in connection with an approved cancer clinical trial.

The term does not include the following items and services in connection with a cancer clinical trial:

1. The costs of the investigational drugs or devices themselves; or

2. The costs of any non-health service that might be required for a Participant to receive the treatment or intervention (e.g., transportation, hotel, meals, and other travel expenses); or

3. The costs of managing the research; or

4. Any cost which would not be covered under the Covered Underlying Plan's benefits for non-investigational treatments.

An approved cancer clinical trial must include a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer in human beings that meets all of the following requirements:

1. The treatment or intervention is provided pursuant to an approved cancer clinical trial that has been funded, authorized or approved by one of the following:

    a. The National Institutes of Health (NIH) including the National Cancer Institute (NCI); or

    b. The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption; or

    c. The United States Department of Veterans Affairs (VA); or

    d. Centers for Disease Control and Prevention (CDC); or

    e. Agency for Healthcare Research and Quality (AHRQ); or

    f. Centers for Medicare and Medicaid Services (CMS)

2. The proposed therapy has been reviewed and approved by the applicable qualified Institutional Review Board.

3. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved cancer clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer.

4. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.

5. The trial consists of a scientific plan of treatment that includes specific goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above.

6. The trial must:

    a. Evaluate a service which is otherwise an Eligible Claims Expense; and

    b. Have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and

    c. Enroll diagnosed Participants.

All other terms and provisions of the Policy will continue to apply.

HM Life Insurance Company

By

President

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/11/2010

Comments:
previously approved application to be used HL-SLA WD and HL-SLA ND both approved on October 19, 2005.

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/11/2010

Comments:
Attachment:
Readability Cert.pdf

		Item Status:	Status Date:
Satisfied - Item:	AR Submission Letter	Approved-Closed	10/11/2010

Comments:
Attachment:
AR 9.2010 Submission Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	Summary of Variables	Approved-Closed	10/11/2010

Comments:
Attachment:
HL601-SL _810_ VARIABLES.pdf

		Item Status:	Status Date:
Satisfied - Item:	response letter	Approved-Closed	10/11/2010

Comments:
Attachment:

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

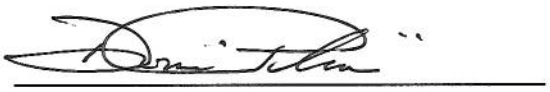
AR 10.2010 response Letter.pdf

STATE OF ARKANSAS

READABILITY CERTIFICATION

This is to certify that the following forms comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch Reading Ease Score of:

FORM NO.	**FLESCH SCORE**
HL 601-SL (810) and related forms	56



Signed by Company Officer

September 27, 2010

Date

Domenic Palmieri
Name

Senior Vice President – Finance
Title

INSURANCE GROUP
A HIGHMARK COMPANY

HM Life Insurance Company
HM Life Insurance Company of New York
HM Casualty Insurance Company
RBS Re
HM Benefits Administrators

September 27, 2010

Arkansas Department of Insurance
Life and Health Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904

VIA SERFF

RE: HM Life Insurance Company, NAIC #93440
Stop Loss Insurance

Form Filing:	HL601-SL (810)	Stop Loss Insurance Policy
	HM STL (810)	Specific Terminal Liability Rider
	HM MAA (810)	Monthly Aggregate Accommodation Rider
	HM CCT	Cancer Clinical Trial Rider
	HM FASLF	Family Aggregating Specific Loss Fund Rider
	HM ASLF (810)	Aggregating Specific Loss Fund Rider
	HM ATL (810)	Aggregate Terminal Liability Rider
	HM SRL	Special Risk Limitation Rider
	HM GR	Bridge Renewal Rider
	HM AAF (810)	Aggregate Advance Funding Rider
	HM SAF (810)	Specific Advance Funding Rider
	HM FSAF	Family Specific Advance Funding Rider
	HM RC	Rate Cap Rider
	HM RG	Rate Guarantee Rider
	HM SLR	Renewal Rider
	HM SLSD	Step-Down Specific Deductible Rider
	HM SLCAA	Continuous Aggregate Accommodation Rider
	HM SLAR	Affiliate Rider
	HM MTR	Medical Travel Rider

To Whom It May Concern:

Enclosed for filing with your department are the captioned forms. When approved, Policy Form HL601-SL (810), et. al. will replace existing business issued on the following forms, at the next renewal following the date of approval:

Form	Approved
HL601-SL (905)	10/19/05 (paper filing)
HL601-SL/DP (905)	10/19/05 (paper filing)
HL601-SL (905) AFR	10/19/06 (paper filing)
HMP-SL 710, et. al.	8/5/10 *(SERFF Tracking ID- HMRK 126728949)*

These forms will also be used for new business issued after the date of approval. Previously approved (10/19/05) Application and Disclosure forms HL-SLA WD and HL-SLA ND, will continue to be used with HL601(810),et.al. HL-SLA WD will be used in those instances when disclosure is required and HL-SLA ND when disclosure is not required.

The forms provide stop loss insurance for groups that retain the services of a third party administrator (TPA). In order to accommodate our policyholders' specific needs, we request that these forms be approved as variable on a general-use basis.

Mailing Address
PO Box 535061
Pittsburgh, PA 15253-5061

Overnight Deliveries
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

www.hminsurancegroup.com

Telephone
412-544-1000
800-328-5433

HM INSURANCE GROUP

A HIGHMARK COMPANY

HM Life Insurance Company

HM Life Insurance Company of New York

HM Casualty Insurance Company

RBS Re

HM Benefits Administrators

Enclosed with this submission you will find a Policy Variables Format Memorandum, which provides explanations for how any of the bracketed language will be altered. You have our assurance we will not add to or revise any language, but only remove language in the manner described in the memorandum. Any variability will be administered within your state's requirements.

The forms contain no unusual or controversial items, according to normal company and industry standards. To the best of my knowledge, the forms comply with all of your applicable statutes.

Should you have any questions or concerns, please do not hesitate to contact me. I may be reached directly at the left-side address, as well as via telephone at 412-544-0923, via fax at 412-544-1138, or via e-mail to jennifer.bayich@hminsurancegroup.com.

Thank you for your time and attention to this matter.

Sincerely,

Jennifer L. Bayich, Esq.

Compliance Analyst III

Enclosures

Mailing Address
PO Box 535061
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POLICY VARIABLES FORMAT MEMORANDUM

HM Life Insurance Company
Stop Loss Insurance HL601-SL (810)

HM Life's policy forms are generated using a state of the art document production system that allows us to select the appropriate variables for each client. The above referenced forms are submitted in final printed form in 10-point type on 8 1/2 by 11 pages and include several types of variables:

1. Optional Provisions

   Optional benefit provisions are these provisions chosen by the client and included or excluded at the client's request and/or provisions which may be used in a specific situation. These provisions are indicated by {Option :} or {Options :} in front of or directly above the benefit description and may be followed by a brief explanation.

2. Bracketed Information

   Used to indicate an amount, percentage, period, duration or choice; in the forms as filed, if a number of variations may be used, the standard options are shown in brackets, or if there are many possible variations, one example may be shown in brackets. A discussion of available amounts, percentages, periods and choices follows:

   Bracketed options in Declaration Page:

A designation or choice	[*]
Covered Claims Basis (both Specific and Aggregate)	[Date] - standard Incurred/Paid basis or Paid basis contracts offered: 12/12, 12/15, 12/18, 12/24, 12/36, 13/12, 14/12. 15/12, 18/12, 24/12, 36/12
Number of Covered Units (both Specific and Aggregate	[*]; number of employees, family members or combination (composite number) entered – may be expressed as: Single Covered Unit Single Plus One Covered Unit Single Plus Two Covered Units Family Covered Unit Composite Covered Unit
Specific Deductible	$[*] - options are Per Participant or Per family; the dollar amount is either a function of premium, or a negotiated limit up to current underwriting guidelines but cannot be less than $5,000 per Participant except as described below: Connecticut - $6,500 West Virginia - $7,500 Alaska, Kansas, Louisiana, Maine, Maryland, Nevada, North Dakota, Oregon, Pennsylvania, Tennessee – $10,000 California – MEWA only, 5% percent of annual expected claims

	Colorado - $15,000 Florida, Minnesota, Missouri, New Hampshire, New York (renewal only), Vermont - $20,000 New Jersey, New York (new business), Oklahoma - $25,000 Washington - 5% of expected claims or $100,000, whichever is less
Specific Payable Percentage (in excess of Specific Deductible)	[*] **%** 80% to 100% in 5% increments
Percentage of Domestic Claims Credited (both Specific and Aggregate)	[*]% - 0% to 100% in 5% increments
Maximum Specific Benefit	$[*] – option are per Plan Year from $1,000,000 to $10,000,000; or per lifetime from $1,000,000 to $10,000,000 or unlimited; can be applied per Participant or per family
Aggregate Payable Percentage (in excess of Specific Deductible)	[*] **%** 80% to 100% in 5% increments
Aggregate Attachment Point (Corridor)	[*] % - 105% to 150% in 5% increments except as described below: Alaska (51 > lives), Florida (51 > lives), Louisiana (51 > lives), Minnesota (51 > lives), Nevada (51 > lives), New Hampshire (51 > lives), North Dakota, Vermont (51 > lives) – 110% Maryland – 115% Alaska (2 - 50 lives), Florida (< 50 lives), Minnesota (< 50 lives), Missouri (< 50 lives), Nevada (< 50 lives), New Hampshire (< 51 lives), Vermont (1-50 lives) - lower than the greatest of: (1) $4,000 times number of individuals; or (2) 120% of expected claims; or (3) $20,000. Colorado, Kansas, Louisiana (< 50 lives), Maine, Missouri (51 > lives), Oklahoma, Oregon, Tennessee, Washington – 120% California (MEWA only), Indiana (Professional Employer Organization only), New Jersey – 125% Iowa: (1) MEWA only - aggregate coverage required; cannot be greater than 120%; (2) Political subdivisions of the state, school corporations, and all other public bodies other than the state of Iowa only – aggregate coverage required; cannot be greater than 125%
Minimum Aggregate Deductible	$[*] dollar amount set by underwriter, or the number of Covered Units used to determine the premium for the first month of the current Policy multiplied by the number of months in that term (Pennsylvania – this deductible will not be less than $100,000)

Annual Aggregate Deductible	Either $[*] dollar amount set by the underwriter or as a function of the calculation shown on the declaration page based on the Monthly Aggregate Deductible
Monthly Aggregate Factor	$[*] dollar amount set by the underwriter per Covered Unit
Maximum Aggregate Claims Expense	$[*] dollar amount set by the underwriter per Covered Unit
Maximum Aggregate Benefit	$[*] dollar amount per Policy Term; capped at $10,000,000

Special Risk Limitations - used to:

- Describe a situation where a separate covered claim basis applies to a Participant, an entire class of employees, or an Affiliate; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Describe instances where certain claim expenses are limited (capped) excluded for the period prior to the effective date of the policy, for a period of time following either the effective date or renewal date, for the entire time the contract is in effect, for a Policy Term, etc.; this may be tailored to apply to a Participant, employee class, Affiliate, limited to certain procedures, or a group of related procedures/ conditions (i.e., organ transplants, AIDS / HIV, mental nervous, alcoholism, substance abuse).
- Describe instances where Participants, all employees of a certain class, an Affiliate, etc. are excluded from the policy; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Describe instances where a Participant requires a higher specific deductible; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Exclude individuals or groups of individual in certain situations (i.e., COBRA participants, Medicare participants, Medicaid participants, domestic partners, late enrollees, employees of an Affiliate, employees in a certain class, etc.); this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude certain types of claims (Excluded Claims Expense) such as organ transplants, AIDS / HIV, mental nervous, alcoholism, substance abuse, etc.; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Apply a preexisting conditions limitation; this may be limited to a dollar amount, defined period of time, for the entire time the contract is in effect, to a Policy Term, an incurred and or paid period, only apply to certain procedures or groups of procedures, a Participant, employee class, Affiliate, etc. Pre-existing Conditions: dollar limits, if included (i.e., $3000) are based on the amount in the Covered Underlying Plan; period of time pre-ex applies to person covered (i.e., 12 months) – may be expressed in terms of a number of days, ranges between three and 24 months; time limit for late enrollees (i.e., 30) range 0 (waived) to 90 days, generally will follow HIPPA guidelines; treatment free period prior to effective date (i.e., 90 days) – may be expressed in terms of months, may range between 24 months and 90 days; limiting age for children (i.e., 18) – generally will follow DOL guidelines, may range between 17 and 25. Standard pre-ex if offered will mirror the underlying medical plan. Standard, if included, will mirror the underlying medical plan.
- Identify a participant for purposes of the above by the last 4 digits of Participant's SS# (if known) and relationship to the Participant (i.e., employee, child, FTS, spouse, handicapped child, etc.) – note, a unique identifier may be used for privacy purposes.
- Modify the specific and/or aggregate benefit calculations to include separate individual deductibles in the calculations.

- Mental Nervous/Drug & Alcohol, Self Reported Symptoms, Self-inflicted Injuries limits are generally based on limits in underlying plan, absent a limit in the underlying plan limits may be based on a specific dollar amount, number of days or a combination of the two per day, lifetime, Plan year, out-patient visit, etc. – range for dollar limit $10,000 to $50,000 or an equivalent per diem limit; range for outpatient 30 to 90 days or an equivalent dollar limit. Standard, if included, will mirror the underlying medical plan.
- Transplant dollar limits – range $0 to $2,000,000
- AIDS dollar limit – range $0 to $2,000,000
- Indicated actively at work out of hospital requirements do not apply
- Include or exclude retirees and any conditions that may apply; for example retirees between certain ages, retired on pension, only those eligible for Medicare, etc.
- Describe conditions that may apply at renewal; for example -

  At renewal we may apply new Special risk Limitations, or extend or revise any current Special Risk limitations

  At renewal we will not add any new Special risk Limitations, or extend or revise any current Special Risk limitations [provided there are no Material Changes].

  At renewal any increase in the Specific Premium Rate will be limited to {Option :} [40%] [45%] [50%] for the next Policy Term. If applicable this increase will apply to the Aggregating Specific Loss Fund Term [provided there are no Material Changes].

  We reserve the right to retroactively adjust Monthly Aggregate Deductible Factors for the current Policy Term if average monthly Eligible Claim Expenses for the [first {Options :} [6] [7] [8] [9] [10] [11] months of the] prior Policy Term are at least {Options :} [5] [10] [15] [20] [25]% lower than the average monthly Eligible Claim Expenses for the {Options :} [month] [2] [3] [4] [5] [6] months immediately prior to the effective date of the current Policy Term.

Other Bracketed options:

- Notice requirements expressed in term of days or months (i.e., [30] / [three]) - number of days may be expressed as: 15, 30, 31, 45, 60, 90, 120, 180; number of months may be expressed as one, two, three, four, five or six; ranges expressed in days may be shown in a monthly equivalent, and those expressed in months may be shown in a daily equivalent.
- Retirement age [65] may be expressed to mirror the Policyholders administration
- U&C percentage [80]%; range 50% to 100%
- Claim within percentage of the Specific Deductible or set dollar amount (i.e., the lesser of [50]% or [$50,000]): range generally10% to 50% / $5,000 to $50,000
- Number of Participants or Covered Units – range 50 to 100
- Percentage of change in number of Participants or Covered Units through the Underlying Plan (i.e., [10]%) – range 5% to 25%
- Notice of Claim (i.e., [20] days) – will never be reduced below 20 days, may be increased up to 90 upon request
- Grace Period (i.e., [31]) – the grace period will never be less than 30 days we may increase to 90 days upon request

3. Riders – all riders are considered optional.

4. Foreign languages - We may issue certificates in a foreign language, based on a direct translation of the filed wording.

5. Customized wording - Text may be customized as a result of negotiations with a client; however, HM Life will not agree to any additional variations or provisions not shown in the enclosed policy forms that are:

- ambiguous or unclear;
- to the best of our knowledge and belief inconsistent with any law, ruling or regulation of any state or the federal government; or
- for which we do not have a rate that is reasonable in relation to the benefit provided.

HM INSURANCE GROUP
A HIGHMARK COMPANY

HM Life Insurance Company
HM Life Insurance Company of New York
HM Casualty Insurance Company
RBS Re
HM Benefits Administrators

September 27, 2010

Arkansas Department of Insurance
Life and Health Division
Arkansas Insurance Department
1200 W. Third Street
Little Rock, AR 72201-1904

VIA SERFF

RE: HM Life Insurance Company, NAIC #93440
Stop Loss Insurance

Form Filing:	HL601-SL (810)	Stop Loss Insurance Policy
	HM STL (810)	Specific Terminal Liability Rider
	HM MAA (810)	Monthly Aggregate Accommodation Rider
	HM CCT	Cancer Clinical Trial Rider
	HM FASLF	Family Aggregating Specific Loss Fund Rider
	HM ASLF (810)	Aggregating Specific Loss Fund Rider
	HM ATL (810)	Aggregate Terminal Liability Rider
	HM SRL	Special Risk Limitation Rider
	HM GR	Bridge Renewal Rider
	HM AAF (810)	Aggregate Advance Funding Rider
	HM SAF (810)	Specific Advance Funding Rider
	HM FSAF	Family Specific Advance Funding Rider
	HM RC	Rate Cap Rider
	HM RG	Rate Guarantee Rider
	HM SLR	Renewal Rider
	HM SLSD	Step-Down Specific Deductible Rider
	HM SLCAA	Continuous Aggregate Accommodation Rider
	HM SLAR	Affiliate Rider
	HM MTR	Medical Travel Rider

Dear Ms. Minor:

Thank you for your review of this filing. In accordance with your objection letter, the war exclusion has been revised to remove the option of excluding acts of terrorism.

A revised Policy form is attached for your review.

Should you have any questions or concerns, please do not hesitate to contact me. I may be reached directly at the left-side address, as well as via telephone at 412-544-0923, via fax at 412-544-1138, or via e-mail to jennifer.bayich@hminsurancegroup.com.

Thank you for your time and attention to this matter.

Sincerely,

Jennifer L. Bayich, Esq.
Compliance Analyst III

Enclosures

Mailing Address
PO Box 535061
Pittsburgh, PA 15253-5061

Overnight Deliveries
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222-3099

www.hminsurancegroup.com

Telephone
412-544-1000
800-328-5433

A HIGHMARK COMPANY

HM Life Insurance Company

HM Life Insurance Company of New York

HM Casualty Insurance Company

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LHP-185 (R12-07)

SERFF Tracking Number:	*HMRK-126833775*	*State:*	*Arkansas*
Filing Company:	*HM Life Insurance Company*	*State Tracking Number:*	*46907*
Company Tracking Number:	*HL601-SL (810)*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Stop Loss*		
Project Name/Number:	*Stop Loss 8/10/HL601-SL (8/10)*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/27/2010	Form	Stop Loss Insurance Policy	10/11/2010	Policy Form HL601-SL (810) clean.pdf (Superceded)

HM LIFE INSURANCE COMPANY

FIFTH AVENUE PLACE, 120 FIFTH AVENUE, PITTSBURGH, PA 15222-3099
1-800-328-5433

POLICY NUMBER	[SPECIMEN]
NAME OF POLICYHOLDER	[SPECIMEN]
TYPE OF COVERAGE	Stop Loss Insurance
EFFECTIVE DATE	[SPECIMEN]
POLICY TERM	[DATE through DATE]
POLICY DELIVERED IN	[STATE] and governed by the laws of that state.

HM Life Insurance Company agrees to pay the benefits provided by this Policy, in accordance with the provisions of this Policy.

The consideration for this Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

This Policy provides benefits to the Policyholder when Eligible Claims Expenses, which are ~~[~~actually~~]~~ Paid by the Policyholder through the Covered Underlying Plan(s), exceed the levels defined in this Policy. The benefits of this Policy and the terms and conditions that apply to this Policy are explained herein.

This Policy begins at 12:01 AM current [Eastern] Time on the first day of the current Policy Term and ends at 11:59 PM current [Eastern] Time on the last day of the current Policy Term, and may be renewed for subsequent Policy Terms. {Option :} If this Policy is renewed the terms and conditions of this Policy may be revised.

This Policy will terminate automatically upon the failure of the Policyholder to pay any premium within the Grace Period. Termination of this Policy for any reason other than non-payment of premium will occur following written notice by the Policyholder or us.

All provisions on this and the following pages are a part of this Policy. The definitions of terms apply whenever the terms are used anywhere in this Policy. "We", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

HM Life Insurance Company

By

President

This Policy is Non-Participating

TABLE OF CONTENTS

Part 1. DECLARATION PAGE

{Option, used on renewal if Declaration Page is replaced :}
[This Declaration Page replaces the Declaration Page for Policy Number and Policyholder shown in A. Policy Information below the for the Policy Term **[(1)]** through **[(1)]** in its entirety.]

A. POLICY INFORMATION

1.	Policy Number	[Specimen]
2.	Policyholder	[Specimen]
3.	Current Policy Term	[Date] through [Date]
4.	Covered Underlying Plan(s)	[Policyholders] [See] [and] [Affiliates]
5.	Claims Administrator	[Specimen]

{Option – Specific Benefit Schedule :}
[A.] SPECIFIC BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually-Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid prior to [Date].

{Option – initial 12/15; current Policy Term revised to 12/24 at renewal :}
[NOTE: If you renew this Policy the Covered Claims Basis for this Policy Term will be revised so that Eligible Claim Expenses include only such expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option - Bridge Renewal :}
During the current Policy Term, any Eligible Claim Expense Incurred prior to the end of that term but actually Paid after the current Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the renewal Policy Term; as such, those expenses are subject to all terms and conditions of the Policy including but not limited to re-satisfying the Specific Deductible.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the Incurred Period and Paid during the Run-out Period for the renewal Policy Term will be considered an Eligible Claim Expense for purposes of that renewal Policy Term.

During any renewal Policy Term, any Eligible Claim Expense Incurred prior to the end of the renewal Incurred Period but actually paid after the renewal Policy Term's Run-out Period will be considered an Eligible Claim Expense for purposes of the subsequent Policy Term as such, those expenses are subject to all terms and conditions of the Policy

including but not limited to re-satisfying the Specific Deductible.

As used above:

"Run-out period" is the {Options :} [three] [six] month period immediately following the end of the current or any subsequent Policy Term.

"Incurred Period" is the period from [original Covered Claims basis incurred date] to the end of the current Policy Term.

2. Specific Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single Covered Unit	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Specific Deductible

{Option – standard offer :}
[Per Participant] $[*]

{Option :}
[Per Family] $[*]

5. Specific Payable Percentage (in excess of Specific Deductible) [*] **%**

{Option - Domestic Claims}
[6.] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] **%]**

[7.] Maximum Specific Benefit

{Option – standard offer :}
[Per Participant in excess of the Specific Deductible]

{Option :}
[Per Family in excess of the Specific Deductible]

{Option :}
[Per Policy Term] [None] [$ [*]]

{Option – standard offer :}
[Per Lifetime] [Unlimited] [$ [*]]

{Option – Aggregate Benefit Schedule :}

[B.] AGGREGATE BENEFIT SCHEDULE

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Covered Claims Basis

{Option, standard offer – Incurred and Paid :}
Incurred & Paid: Eligible Claims Expenses Incurred from [Date] through [Date] and actually Paid from [Date] through [Date].

{Option – from date Paid :}
Paid: Eligible Claims Expenses Incurred on or after [Date] [and] actually Paid from [Date] through [Date].

{Option – true Paid :}
Paid: Eligible Claims Expenses actually Paid from [Date] through [Date].

2. Aggregate Eligible Claims Expenses include:

Health Care	[*] Yes [*] No
Dental	[*] Yes [*] No
Vision	[*] Yes [*] No
Prescription Drug Card	[*] Yes [*] No
Short Term Disability	[*] Yes [*] No
Other: [Specimen]	[*] Yes [*] No

3. Number of Covered Units

Single	[*]
[Single Plus One]	[*]
[Single Plus Two]	[*]
[Family]	[*]
[Composite]	[*]

4. Aggregate Payable Percentage (excess of Deductible): [*] %

{Option – may be removed if the corridor is a function of the monthly aggregate deductible calculation :}

[5.] [Aggregate Attachment Point (Corridor) [*] %]

{Option :}

[6.] [Minimum Aggregate Deductible $[*]]

[7.] Annual Aggregate Deductible

{Option – only used if a monthly aggregate deductible is not calculated :} [$[*]]

{Option, standard offer :}
[is equal to [A], [B] or [C] whichever is greater, where:

{Option - either A, B or both may be included:}
[A] [= The Monthly Aggregate Deductible Amount for the initial Policy Month times * the number of months in the current Policy Term]

{Option :}
[B] [= The sum of the Monthly Aggregate Deductible Amounts applicable to each Policy Month [in] the current Policy Term]

{Option :}
[C] = [The Minimum Aggregate Deductible]

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the Aggregate Monthly Deductible Amounts have been calculated for each Policy Month of the Policy Term.

{Option :}
Note: The Annual Aggregate Deductible cannot be finally determined until the end of the Policy Term.

{Option – only used if a Monthly Aggregate Deductible is computed:}
[8.] [Monthly Aggregate Factor

{Option :}
[Per Single Covered Unit per Policy Month] $[*]

{Option :}
[Per Single Plus One Covered Unit per Policy Month] $[*]]

{Option :}
[Per Single Plus Two Covered Unit per Policy Month] $[*]]

{Option :}
[Per Family Covered Unit per Policy Month] $[*]]

{Option :}
[Per Composite Covered Unit per Policy Month] $[*]]]

{Option – used if aggregate claims expenses are limited :}
[9.] [Maximum Aggregate Eligible Claims Expense

{Option :}
[Per Single Covered Unit) $[*]

Option :}
[Per Single Plus One Covered Unit] $[*]]

[Per Single Plus Two Covered Unit] $[*]]

{Option :}
[Per Family Covered Unit] $[*]]

{Option :}
[Per Composite Covered Unit] $[*]]

{Option - domestic claims :}
[10] [Percentage of Domestic Claims Credited
(percentage that qualifies as an Eligible Claims Expense) [*] %]

[11.] Maximum Aggregate Benefit (in excess of the

Annual Aggregate Deductible) per Policy Term) $[*]

[C.] PREMIUM

{Option, standard :}
[Specific Premium per Month

Single Employee:	$[*]
Single Plus One	$[*]
Single Plus Two	$[*]
Family:	$[*]
Composite:	$[*]

{Option :}
[Minimum Annual Specific Premium: $ [*]]

[Initial][Specific] Rate Guarantee Period [*] Months]

{Option :}
[Aggregate Premium per Month Per Covered Unit: $ [*]]

[Minimum Annual Aggregate Premium: $ [*]]

The Specific Premium per Month [and the Aggregate Premium per Month per Covered Unit] only apply to the current Policy Term.

{Options, see variable summary; Special Risk Limitation used to:

- Describe an Alternate Specific deductible for a Covered Units or Covered Family Units.
- Describe instances where certain claim expenses are limited (capped) excluded for the period prior to the effective date of the policy, for a period of time following either the effective date or renewal date, for the entire time the contract is in effect, for a Plan Year, etc.; this may be tailored to apply to a Participant, employee class, Affiliate, limited to certain procedures, or a group of related procedures/ conditions.
- Describe instances where Participants, all employees of a certain class, an Affiliate, etc. are excluded from the policy; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude individual or groups of individual in certain situations (i.e., COBRA participants, Medicare participants, Medicaid participants, domestic partners, late enrollees, employees of an Affiliate, employees in a certain class, etc.); this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, etc.
- Exclude or place an internal limit on certain types of claims expenses; this may be limited to a defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, etc.
- Apply a preexisting conditions limitation; this may be limited to a dollar amount, defined period of time, for the entire time the contract is in effect, to a Plan Year, an incurred and or paid period, only apply to certain procedures or groups of procedures, a Participant, employee class, Affiliate, etc.
- Apply a separate run-in or run-out limit to a location, affiliate or employee class :}

[D.] SPECIAL RISK LIMITATIONS:

[None]

[Specific [See variable summary]]

[Aggregate [See variable summary]]

[E.] AFFILIATES

{Option, if no affiliates "none is used; if there are affiliates name(s) of affiliates are listed; if all affiliates have the same underlying plan as the policyholder "same as policyholders is listed – if different than policyholders plan's name /designation is entered :}
[None]

[Name]	[Covered Underlying Plan(s)]
[Specimen]	[Same as Policyholders]

Part 2. BENEFITS

{Option – Specific :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule and Policy Term are shown on the Declaration Page.

{Option – Aggregate and Specific :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Specific Benefit Schedule or the Aggregate Benefit Schedule, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Specific Benefit Schedule and Aggregate Benefit] Schedule and Policy Term are shown on the Declaration Page.

{Option – Aggregate :}
Unless otherwise indicated in the Covered Claims Basis section(s) in the Aggregate Benefit, benefits under this Policy will only be paid by us based on Eligible Claims Expenses through the Covered Underlying Plan(s) which are [Incurred] [and] [or] [actually] [Paid] after the Effective Date of this Policy and which are [actually] Paid by the Policyholder during the Policy Term. The Aggregate Benefit and Policy Term are shown on the Declaration Page.

{Option – Specific Benefit per participant:}
[A.] SPECIFIC BENEFIT

We will pay to the Policyholder the following Specific Benefits, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Participant will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Participant minus (A plus B), where:

A = The Specific Deductible for the Participant

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan

Times the Specific Payable Percentage

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

{Option – Excluded Claims Expenses :}
[The Specific Benefit payable does not include any amount [actually] Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

{Option – removed with unlimited lifetime max and no policy term max}
[In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by any one Participant exceed the Maximum Specific Benefit.]

{Option – Specific Benefit per family:}
[A.] FAMILY SPECIFIC BENEFIT

We will pay the Policyholder, the following Specific Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Specific Benefit payable with respect to a Family will equal the amount of Eligible Claims Expenses which are actually Paid by the Policyholder for such Family during the current Policy Term minus (A plus B)) where:

A = The Specific Deductible for the Family.

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan.

Times the Specific Payable Percentage

We will pay Specific Benefits as they become due following satisfaction of the Specific Deductible, subject to the terms and conditions of this Policy.

{Option – Excluded Claims Expenses :}
[The Specific Benefit does not include any amount [actually] Paid by the Policyholder for the Policy Term for Excluded Claims Expenses.]

{Option – removed with unlimited lifetime max and no policy term max}
[In no event will the Specific Benefit paid by us with respect to Eligible Claims Expenses Incurred by all members of the same Family] exceed the Maximum Specific Benefit.]

{Option – standard offer; calculation includes monthly factor and a maximum aggregate eligible claims expense :}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit, in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal the total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term minus (A plus B plus C), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

{Option – calculation does not include a monthly factor, but assumes a maximum aggregate eligible claims expense :}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term times the Aggregate Attachment Point (Corridor) minus (A plus B plus C), where:

A = The Annual Aggregate Deductible for the Policy Term.

B = Any amount in excess of the Maximum Monthly Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

C = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

{Option – calculation includes monthly factor or a maximum aggregate eligible claims expense:}
[B.] AGGREGATE BENEFIT

We will pay the Policyholder an Aggregate Benefit in accordance with the terms of settlement mutually agreed upon by the Policyholder and us.

The Aggregate Benefit payable will equal:

The total amount of the Aggregate Eligible Claims Expenses which are actually Paid by the Policyholder for all Covered Units during the current Policy Term times the Aggregate Attachment Point (Corridor) minus (A plus B), where:

A = The amount actually Paid by the Policyholder in excess of the Maximum Monthly Aggregate Eligible Claims Expense per [Participant] [Family] [Covered Unit]

B = Any amounts actually Paid for Covered Expenses Incurred by a Participant later recovered through any recovery provision of this Policy or the Covered Underlying Plan(s).

Times the Aggregate Payable Percentage

{Option – Excluded Claims :}
[The Covered Claims Basis for the Aggregate Benefit during the Policy Term does not include any amount actually Paid by the Policyholder for Excluded Claims Expenses.]

We will pay the Aggregate Benefit at the end of each Policy Term, subject to the terms and conditions of this Policy.

In no event will the Aggregate Benefit paid by us for the Policy Term exceed the Maximum Aggregate Benefit per Policy Term shown in the Aggregate Benefit Schedule.

Part 3. EXCLUSIONS AND LIMITATIONS

No Deductible of this Policy will be satisfied and no benefit of this Policy will be paid for:

[*] UNDERLYING PLAN: Any amount actually Paid by the Policyholder for an expense Incurred:

a. When the Covered Underlying Plan is not in effect; or

b. By a person who is not a Participant when the expense is Incurred; or

c. That is not specifically covered under the terms of the Covered Underlying Plan, or that the Policyholder is not required to pay in accordance with the terms of the Covered Underlying Plan; or

d. Prior to the initial Incurred date shown in Covered Claims Basis on the Declaration Page.

{Option - standard, may be removed or replaced with misrepresentation upon request :}
[*] [NONDISCLOSURE: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant who:

a Was a Participant at the time of the initial underwriting of this Policy, but whose Known medical conditions were not accurately Disclosed to us at that time by the Policyholder or the Policyholder's Claims Administrator.

b. Was a Participant at the end of the Policy Term, but whose Known medical conditions were not accurately Disclosed to us by Policyholder or the Policyholder's Claims Administrator prior to the date this Policy is renewed for a subsequent Policy Term.

{Option :}
[c.] [Becomes a Participant after the {Options :} [initial underwriting] [Effective Date] of this Policy, but whose Known medical conditions were not accurately Disclosed to us before

the effective date of his or her coverage through the Covered Underlying Plan(s) by the Policyholder the Policyholder's Claims Administrator.]

{Option :}

[d.] [Becomes a Participant after the {Options :} [initial underwriting] [Effective Date] of this Policy, but whose Known medical conditions were not accurately Disclosed to us by the Policyholder or the Policyholder's Claims Administrator before the date the Policyholder acquires another Affiliate, establishes another class of employees eligible for coverage through the Covered Underlying Plan(s).]]

{Option, may be substituted for nondisclosure provision or removed upon request :}

[*] [MISREPRESENTATION: Any amount which is actually Paid by the Policyholder for an expense which is Incurred by a Participant if Claim Information was requested prior to the beginning of any Policy Term~~]~~, and either the requested Claim Information was not provided or the Known Claim Information provided was inaccurate or incomplete in a material respect .]

{Standard, may be removed upon request :}

[*] [OTHER COVERAGE: The amount of any expenses for benefits to any Participant with coverage under any other plan which, when combined with the benefits payable by such other plan, would cause the total paid by that plan and the Covered Underlying Plan(s) to exceed 100% of the Participant's actual expenses.]

[*] [ADMINISTRATIVE COSTS: Any amount, which is actually Paid by the Policyholder for;

a. Administrative costs, including but not limited to, administrative costs for claim payments, networks, case management fees in excess of the usual and customary charge, PPO access fees and Prescription Drug administration fees; or

b. Capitation fees ; or

c. The expense of litigation; or

d. Extra contractual damages, compensatory damages, or punitive damages.]

{Option :}

[*] [WAR: Any amount ~~[~~actually~~]~~ Paid by the Policyholder for Eligible Claims Expenses which arise out of or are caused or contributed to by war or an act of war {Option:} [unless a Participant is required to be in a location where a war or act of war has or may occur as a condition of employment with his or her Employer~~]~~.

WAR means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature. {Option:} [This term includes acts of terrorism.]

{Option - version 1:}

[*] [WORK RELATED: Any amount ~~[~~actually~~]~~ Paid by the Policyholder through the Covered Underlying Plan(s) for any injury or illness which is eligible for coverage under a workers' compensation or occupational disease policy or agreement, whether or not such policy or agreement is actually in force and whether or not such benefits are received by the Participant.]

{Option - version 2:}

[*] [WORK RELATED: An injury or illness incurred or contracted in the course of any employment for wage or profit.]

{Option :}

[*] [FELONY: Any amount [actually] Paid by the Policyholder for Eligible Claims Expenses for any period caused or contributed to by a Participant committing or attempting to commit an assault, felony or participating in an illegal occupation, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties.]

{Option :}

[*] [FOREIGN MEDICAL CARE: Any amount incurred by a Participant for the cost of [drugs] procedures, services, supplies or treatments[, other than drugs received from a licensed Canadian pharmacy or pharmacist,] rendered or received in person[, by mail or otherwise] outside the United States if the purpose of such travel [or communication] is to obtain or receive such service, supply or treatment.]

{Option :}

[*] [USUAL AND CUSTOMARY CHARGE: Any amount which is [actually] Paid by the Policyholder in excess of the usual and customary charge for the Covered Service, as defined and/or applied by the Covered Underlying Plan(s).]

{Option :}

[*] [EXPERIMENTAL OR INVESTIGATIONAL: Any amount which is [actually] Paid by the Policyholder for the cost of drugs, procedures, services, supplies or treatments which are considered experimental or investigational.]

{Option :}

[*] [NOT MEDICALLY NECESSARY: Any amount which is [actually] Paid by the Policyholder for the cost of procedures, drugs, treatments, services, or supplies which are not medically necessary and appropriate, as determined by the Food and Drug Administration, the American Medical Association, their successor organization(s), or other generally accepted medical compendia.]

{Option :}

[*] [LOST PROVIDER DISCOUNTS: Provider discounts of any kind lost due to untimely payment of claims by the Policyholder [or the Policyholder's authorized representative].]

{Option :}

[*.] [RETIRED: Any amount which is [actually] Paid by the Policyholder for an expense which is Incurred by a Participant.

{Option – has retired:}
who has retired[,][.]

{Option – was retired:}
who was retired[,][.]

{Option – after date eligible:}
except for any Participant who retires on or after [(specimen)] and is still covered under the Covered Underlying Plan(s).

{Option – prior to age until age eligible:}
except this limitation will not apply to any Participant who retires prior to age [65] and is still covered under the Covered Underlying Plan(s) until that person attains [65] years of age.

{Option – prior to normal retirement age:}
except this limitation will not apply to any Participant who retires prior to his or her normal retirement age and is still covered under the Covered Underlying Plan(s) until that person attains his or her normal retirement age [as defined] [by the [Policyholder].]

{Option :}

[*] [EXCESS REIMBURSEMENT: Any amount in excess of the fee, reimbursement percentage or other form of payment negotiated with a provider or facility by the Applicant[,] Policyholder [or] [Designated TPA] as total reimbursement to the provider or facility for the cost of drugs, procedures, services and supplies through the Covered Underlying Plan(s).]

Part 4. CLAIMS ADMINISTRATOR

The Policyholder must retain a Claims Administrator at all times. All Claims Administrators must be approved by us. The Claims Administrator performs as the Policyholder's agent and we will not be held liable for any act or omission of the Claims Administrator.

We will only reimburse the Policyholder for Eligible Claims Expenses paid by an approved Claims Administrator.

The Claims Administrator will:

1. Supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims in accordance with the terms of the Covered Underlying Plan;

2. Maintain accurate records of all claim payments;

3. Maintain separate records of expenses not covered; and

4. Provide us with the following data for the preceding Policy Month on or before the 30th day of each succeeding Policy Month:

   a. notice of claims that reach 50% of the Specific Deductible; and
   b. number of Covered Units or Covered Family Units;
   c. total amount of claims paid.

5. Secure and keep renewed, at their expense, all licenses, permits, authorizations or certificates of authority in the states where the Claims Administrator conducts the business of insurance in accordance with statutory requirements.

We will not be responsible for any compensation due to the Claims Administrator for functions performed by the Claims Administrator for the Policyholder.

This Policy will not be deemed to make us a party to any agreement between the Policyholder and the Claims Administrator.

For the purpose of any notice required from us under the provisions of this Policy, notice to the Policyholder's Claims Administrator will be considered notice to the Policyholder and notice to the Policyholder will be considered notice to the Policyholder's Claims Administrator.

Part 5. CLAIM PROVISIONS

A. NOTICE OF CLAIM

The Policyholder or the Policyholder's Claim's Administrator must notify us within {Option :} [20] [30] days of the date:

1. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) for a Catastrophic Claim, Large Claim or Shock Loss; or.

2. The Policyholder or the Policyholder's Claims Administrator is notified that a Participant has Incurred Eligible Claims Expenses through the Covered Underlying Plan(s) that exceed 50% of the Specific Deductible {Option :} [, or $50,000, whichever is less].

Failure to give notice within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice in time and that notice was given as soon as was reasonably possible. The notice to us must include:

1. The identity of or unique identifier associated with the Participant.

2. A description of the illness or accident and the prognosis.

3. A listing of the Eligible Claims Expenses Incurred by or Known to the Policyholder to date through the Covered Underlying Plan(s).

B. PROOF OF LOSS

The Policyholder or the Policyholder's Claims Administrator must provide satisfactory proof of loss to support a claim within {Options; 90 standard :} [90] [120] [180] [365] days after the end of the current Policy Term or the end of the Paid period shown in Covered Claims Basis for the current Policy Term, if later {Option :} [or as soon thereafter as reasonably possible and, in any case, within 365 days after the end of that 90 day period]. Claims not filed within {Option, used for 90 days :} [this] {Option, used if a 365 day limit applies:} [these] time limits will be denied and no benefits will be paid by us.

Upon presentation of satisfactory proof of loss the Policyholder represents that all monies necessary to pay for services and supplies have been paid to the Participant or respective providers of medical services or supplies to which the claim for reimbursement under the Policy relates.

{Option:}
[C. PAYMENT OF CLAIM

Subject to satisfactory written proof of loss, any benefits payable under the Policy will be paid within {Options; 45 standard :} [30] [45] [60] days immediately following our written receipt of such proof of loss.]

Part 6. MATERIAL CHANGES

We reserve the right to approve any Material Change or Change. The Policyholder or the Policyholder's Claims Administrator must notify us of any Change in writing prior to the effective date of such Change.

Upon receipt of a Material Change we reserve the right to:

1. Accept the Change without revising the Premium Rates and/or other terms and conditions of this Policy; or.

2. Accept the Change and revise the Premium Rates and/or other terms and conditions of this Policy; or.

3. Not accept the Change and pay benefits under this Policy as if the Change had not occurred.

{Option :}
[4.] [Not accept the Change and terminate this Policy.]

If we accept the Change we will consider the Change approved on the date of the Change.

Payment of any benefits under this Policy based on a Change is subject to the Policyholder's [written] acceptance of any necessary adjustment to the premium.

Part 7. TERMINATION AND RENEWAL

A. TERMINATION

This Policy and all coverage under this Policy will terminate **{Option:}** 11:59 PM current [Eastern] Time on the earliest of the following dates:

1. The end of the last period for which premiums were paid.

2. The Premium Due Date next following receipt by us of written notice from the Policyholder that this Policy is to be terminated.

3. The end of any Policy Term, following {Option, 30 standard :} [30] [60 [90] [120] [180] days prior written notice to the Policyholder of termination.

4. The Premium Due Date following {Option, 30 standard :} [30] [60] [90] [120] [180] days prior written notice to the Policyholder that we are planning to terminate this Policy because: {Options:}

   [a.] [there are fewer than {Option, 50 standard :} [25] [50] {Option, Covered Units standard :} [Covered Units] [Participants];or]

   [b.] [the number of {Option, Covered Units standard :} Covered Units] [Participants] has changed by {Option, 10% standard :} [10%] [15%] [20%] [25%];or]

   [c.] [we have refused to accept a Material Change;or]

   [d.] [the Policyholder has refused to accept any necessary adjustment to the premium due to a Material Change; or].

   [e.] [Termination of the Covered Underlying Plan(s); or]

   [f.] [Cancellation of the administrative agreement between the Policyholder and the Claims Administrator, unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection in writing].

{Option, use without prior notice requirement :}
[5. The date the Covered Underlying Plan(s) and all coverage under such plan(s) end.]

{Option, use without prior notice requirement :}
[6. The date of cancellation of the administrative agreement between the Policyholder and the Claims Administrator, [unless the Policyholder has selected another administrator prior to such cancellation and we have consented to the Policyholder's selection [in writing].]

{Option :}
[7. On any date mutually agreed to by the Policyholder and us.]

{Option:}
If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior

to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates.

{Option:}
If this Policy terminates prior to the end of the current Policy Term, the Covered Claims Basis of this Policy will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates. {Option:} However, if this Policy terminates prior to the end of the Policy Term, the Aggregate Benefit, if any, will not be pro-rated and the full Minimum Aggregate Deductible will still apply to Eligible Claims Expenses [Incurred] [and] [or] [actually] [Paid] {Option:} [prior to] [by 11:59 PM current [Eastern] Time on the date this Policy terminates.

{Option :}
If this Policy terminates prior to the end of the current Policy Term:

1. The Aggregate Benefit, if any, will not be payable; and

2. The Covered Claims Basis shown in the Specific Benefit Schedule will be limited to Eligible Claims Expenses Incurred and actually Paid {Option :} [prior to] [by] 11:59 PM current [Eastern] Time up to the date this Policy terminates.

B. RENEWAL

Unless terminated during or prior to the end of current Policy Term, this Policy may be renewed at the end of any Policy Term. At renewal we reserve the right to revise the terms and conditions that apply to the Policy including the rates, Deductibles, and the terms and conditions of this Policy by providing written notice to the Policyholder.

Renewal is subject to:

1. Receipt of any requested Claim Information prior to the beginning of the subsequent Policy Term; and
2. The Policyholder's written acceptance of the terms and conditions that apply to the renewal prior to the beginning of the subsequent Policy Term.

Part 8. PREMIUMS

A. AMOUNT OF PREMIUMS

Premium is calculated based upon the number of Covered Units reported in any given Policy Month. The number of Covered Units for each Policy Month will be determined in accordance with the definition of Covered Unit. The estimated number of Covered Units for the first Policy Month shown in the {Option :} [Specific Benefit Schedule] {Option :} [and] [Aggregate Benefit Schedule] is based on the estimated initial enrollment.

B. CHANGES IN PREMIUM RATES

We reserve the right to change any rate or percentage used in determining the monthly premium. The change may occur on one of the following dates:

1. On any Premium Due Date, if the number of [Participants] [Covered Units] changes by more than {Option:} [10%] [15%] [20%] [25%] {Option :} [from the number reported at the end of the previous Policy Month] {Option; standard :} [on the Effective Date of this Policy or the number on the date of the last Policy Anniversary, whichever is the later date].

{Option:}
[2.] [Retroactively to the beginning of the Policy Term, if we determine that claim payments

are not being made in accordance with the terms and conditions of the Covered Underlying Plan(s).]

{Option, version 1:}
[3.] On the date of any Material Change approved by us.

{Option, version 2:}
[3.] [On the Premium Due Date following the] date we approve any Material Change, if such Change is expected to change Eligible Claims Expenses actually Paid by the Policy by more than {Option:} [10%] [15%] [20%] [25%].]

{Option :}
[4.] [The date of an administrative agreement between the Policyholder and a new Claims Administrator is effective provided we have consented to the Policyholder's selection [in writing].]

{Option :}
[5.] [On any Premium Due Date, if any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of Participants, or a change in law or legislation changes the nature of the risk assumed under this Policy by more than {Option:} [10%] [15%] [20%] [25%].]

{Option, standard included unless a rate guarantee period or rate cap applies :}
[6.] [On any Policy Anniversary.]

{Option :}
[7.] [At the end of any Policy Term.]

We will give the Policyholder {Option, 30 standard :} [30] [45] [60] [90] [120] [180] days prior written notice of any change in any rate or percentage used in determining the monthly premium.

C. PAYMENT OF PREMIUMS

All premiums are due on the applicable Premium Due Date. Each premium is payable by the Policyholder on or before the Premium Due Date direct to us at our Home Office. The payment of each premium as it becomes due will maintain this Policy in force through the date immediately preceding the next Premium Due Date.

D. GRACE PERIOD

A Grace Period of {Option, 31 standard :} [31] [45] [60] [90] days will be allowed for the payment of each premium after the first premium. Should a premium which is otherwise due not be paid during the Grace Period, this Policy will automatically terminate on the last day of the Policy Month for which premiums were last paid at 11:59 PM current [Eastern] Time, without further notice to the Policyholder. Our liability will be limited to Eligible Claims Expenses that are Paid by the Policyholder prior to 11:59 PM current [Eastern] Time on last day of the Policy Month for which premiums were last paid.

{Option :}
[E. PREMIUM ADJUSTMENTS

Any retrospective request by the Policyholder for a premium adjustment due to a misstatement of Covered Units must be made within {Options :} [30] [45] [60] [90] [120] [180] days following the end of the current Policy Term. Such requests must be in writing and accompanied by evidence that an adjustment should be made. Any premium adjustment is limited to the number of Policy Months in the prior Policy Term.]

Part 9. GENERAL PROVISIONS

A. HOLD HARMLESS

1. The Policyholder agrees to hold us harmless from any legal expenses incurred or judgments awarded arising out of any dispute involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), to the extent such legal expenses or judgments were not incurred as a result of our [intentional] negligence or intentional wrongful acts.

   If we are notified that we have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s) we will give the Policyholder written notice of the dispute within {Option :} [a reasonable time] [15] [30] [45] [60] [days] . We will make all probative material available to the Policyholder upon written request from the Policyholder. We will cooperate with the Policyholder in matters pertaining to the dispute. However, such cooperation with the Policyholder will not waive our right to solely defend or settle any such action in any manner we deem prudent.

2. We agree to hold the Policyholder harmless from any legal expenses incurred or judgments(s) awarded arising out of any breach of this Policy by us arising out of our negligence or wrongful acts to the extent such legal expenses or judgments(s) were not incurred as a result of the Policyholder's intentional negligence or intentional wrongful acts.

   If the Policyholder is notified that they have been named, or are likely to be named, as a defendant in any action involving a current or former Participant in the Policyholder's Covered Underlying Plan(s), the Policyholder will give us written notice of the dispute within {Option :} [a reasonable time] [15] [30] [45] [60] [days]. The Policyholder will make all probative material available to us upon our written request. The Policyholder will cooperate with us in matters pertaining to the dispute. However, such cooperation will not waive the Policyholder's right to solely defend or settle any such action in any manner they deem prudent.

B. TAXES

The Policyholder agrees to hold us harmless from any state premium taxes incurred with respect to funds paid to or by the Policyholder through the Covered Underlying Plan(s). If any state premium tax is assessed against us with respect to such funds, the Policyholder must reimburse us for the amount of the state premium tax liability including any interest, penalty and costs incurred by us as a result of the assessment. Taxes incurred with respect to premiums paid for this Policy will be our responsibility.

C. NOTICE OF OBJECTION

Any objection, notice of legal action, or complaint received on a claim processed by the Policyholder or the Claims Administrator and on which it reasonably appears a benefit will be payable to the Policyholder under this Policy, must be brought to the immediate attention of our claims department.

D. POLICY NON-PARTICIPATING

This Policy is non-participating and does not share in our surplus earnings.

E. OFFSET

We have the right to offset any benefits payable to the Policyholder under this Policy against premiums due and unpaid by the Policyholder, but this right will not prevent the termination of this Policy for the non-payment of premium.

F. RECOVERY

The Policyholder must prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder and must account to us for any amounts recovered.

{Option – subrogation; not used with right of recovery and subrogation and/or right of recovery :}
[However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we will subrogate the recovery of such claims on behalf of the Policyholder.]

{Optional - right of recovery; not used with subrogation or subrogation and/or right of recovery :}
[However, if the Policyholder does not prosecute any and all valid claims that the Policyholder may have against third parties arising out of any occurrence resulting in a payment for Eligible Claims Expenses by the Policyholder within a reasonable period of time, we will require the Policyholder to assign us the right to prosecute such claims on behalf of the Policyholder.]

{Option, standard - subrogation and/or right of recovery; not used with subrogation or right of recovery :}
[At that time we may, at our option, bring legal action to recover from the third party the amount of any benefits we paid to the Policyholder in connection with the payment of Eligible Claims Expenses caused by the third party's negligence or wrong-doing. The Policyholder will be required to provide us with any legal instruments, documents, or a paper we may need to exercise our right to recover and the Policyholder is prohibited from doing anything to prejudice our right to recover payments from the third party.]

G. REIMBURSEMENT

In the event that the Policyholder recovers from a third party with respect to any Eligible Claims Expenses for which benefits were paid under this Policy, the Policyholder must repay us. The full amount of any and all such funds recovered must be returned to us first before any Deductible under this Policy will be satisfied. No part of any Eligible Claims Expense which is [actually] Paid by the Policyholder and for which the Policyholder has been reimbursed by a third party may be used to meet any Deductible under this Policy. This provision will survive the termination of this Policy.

H. WAIVER

Our failure to insist upon the Policyholder's or the Policyholder's Claim Administrator's strict compliance with any requirement or condition of this Policy at any time or under any circumstance will not constitute a waiver of any such requirement or condition by us at any time under the same or different circumstances.

{Option :}
[I.] ARBITRATION

{Option, binding :}
In the event of a dispute between the parties to this Policy upon which an amicable understanding cannot be reached, either party has the right to refer the dispute to binding arbitration.

The Court of Arbitrators, which is to be held in the city where the home office of the Policyholder is located, will consist of three arbitrators familiar with the Covered Underlying Plan(s) and/or stop loss insurance policies. One of the arbitrators will be appointed by the Policyholder, one by us, and the first two appointees prior to the beginning of the arbitration will select the third.

Should the two arbitrators be unable to agree upon the choice of a third, the appointment will be left to the President or any Vice President of the American Arbitration Association. The arbitrators are empowered to decide all questions or issues and will be free to reach their decision by application of principles of equity and customary practice of the Insurance and reinsurance industry rather than by strict application of all rules of evidence and law. They will decide by a majority of votes and there will be no right of appeal from their written decision. The cost of arbitration, including the fees of the arbitrators, will be borne by the losing party unless the arbitrators decide otherwise.

{Option, non binding :}
In the event of a dispute between the parties to this Policy as to whether coverage is provided under this Policy for a claim made by or against the Policyholder, both parties may, by mutual consent, agree in writing to arbitration of the disagreement.

If both parties agree to arbitrate, each party will select an arbitrator. The two arbitrators will select a third arbitrator. If they cannot agree within 30 days upon a third arbitrator, both parties must request that selection of a third arbitrator be made by a judge of a court having jurisdiction.

Unless both parties agree otherwise, arbitration will take place in [Allegheny County, Pittsburgh, PA].

Local rules of law as to procedure and evidence will apply.

A decision agreed to by any two will be binding. Each party will:

1. Pay the expenses it incurs; and

2. Bear the expenses of the third arbitrator equally.

Part 10. RECORDS AND REPORTS

A. REPORTING

The Policyholder or the Policyholder's Claims Administrator must:

1. Keep appropriate records regarding administration of the Covered Underlying Plans; and

2. Allow us to review and copy, during normal business hours, all records affecting our liability under this Policy; and

3. Submit {Option :} [or allow access to] all proofs, reports, and supporting documents requested by us, including, but not limited to, a monthly summary of all Eligible Claims Expenses which were processed by the Policyholder or the Policyholder's Claims Administrator on a timely basis.

Clerical error, whether by the Policyholder or by us, will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

B. AUDITS

We reserve the right to inspect and audit all of the Policyholder's and the Policyholder's Claims Administrator's records and procedures that pertain to this Policy prior to or after processing a claim for benefits. We also reserve the right to require proof that payment of Eligible Claims Expenses has been made to the Participant or the provider of the Covered Services that are the basis for any claim by the Policyholder under this Policy.

[C.] UNDERWRITING INFORMATION

We rely on the underwriting information and Claim Information [provided] [Disclosed] by the Policyholder or the Policyholder's Claims Administrator:

1. To issue this Policy; and

2. To accept a person as a Participant; and

3. [The Claim Information provided] to renew this Policy.

Should additional information become Known after one of these events that affects the rates, deductibles, or the terms and conditions of this Policy, we reserve the right to revise the rates, deductibles, and the terms and conditions of this Policy retroactive to the effective date of the current Policy Term by providing written notice to the Policyholder.

Part 11. LIABILITY AND INDEMNIFICATION

A. LIABILITY

We will have neither the right nor the obligation under this Policy to directly pay any Participant or provider of Covered Services for any benefit that the Policyholder has agreed to provide through the terms of the Covered Underlying Plan(s). Our sole liability under this Policy is to the Policyholder.

B. INDEMNIFICATION

To the extent we suffer any liability, loss or expense due to a misstatement or failure to provide any Known o requested information, or failure to provide any additional information requested by us on a Participant or a person for whom we have requested [Disclosure [or] Claim Information, the Policyholder agrees to indemnify us up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

To the extent the Policyholder suffers any liability, loss or expense due to our breach of this Policy or due to our negligence or wrongful acts, we agree to indemnify the Policyholder up to the amount of such liability, loss or expense, and all costs associated with such liability, loss or expense.

Part 12. ENTIRE CONTRACT, CHANGES

The entire contract consists of:

1. The pages of this Policy including any amendments, endorsements or riders; and

2. The Application; and

3. Submitted Claim Information; and

{Option :}
[4.] [Disclosure Statements and Disclosure Forms; and]

[5.] Attached documents necessary for the administration of this Policy.

This Policy or the Policyholder's coverage under this Policy may be amended at any time by mutual consent between the parties. No change in this Policy will be valid unless it is approved in writing by one of our executive officers and delivered to the Policyholder for attachment to this Policy. This approval must be shown on or attached to this Policy. No Agent or Designated TPA has authority to change this Policy or to waive any of its provisions.

Part 13. INCONTESTABLE CLAUSE

In the absence of fraud, any statement made by the Policyholder is a representation and not a warranty. No statement made by the Policyholder effecting this Policy will be used to deny a claim or to deny the validity of this Policy unless contained in a written instrument signed by the Policyholder and a copy of the written instrument has been given to the Policyholder.

Part 14. LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy until 60 days after written proof of loss has been furnished to us. No such action may be brought more than three years after the time within which proof of loss is required to be furnished.

Part 15. INSOLVENCY

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Claims Administrator will not impose upon us any liability other than the liability defined in this Policy.

Part 16. ASSIGNMENT

{Option :}
No assignment of interest under this Policy will be binding upon us unless and until the original or a duplicate is on file with us. We do not assume any responsibility for the validity of an assignment.

{Option :}
The Policyholder’s rights and benefits under this Policy cannot be assigned.

Part 17. DEFINITIONS

AFFILIATE means a company subsidiary to, affiliated with, or controlled by the Policyholder. Eligible Affiliates are shown in the Declaration Page. Additions and terminations may only be made by amendment to coverage under this Policy. Termination of an Affiliate is treated as termination of coverage for that company only.

AGENT means the Policyholder’s representative, including but not limited to, the agent, producer or broker of record, or Claims Administrator.

{Option :}
[ANNUAL AGGREGATE DEDUCTIBLE means the dollar amount of Aggregate Eligible Claims Expenses that must be actually Paid by the Policyholder during any Policy Term for all Covered Units before an Aggregate Benefits becomes payable to the Policyholder.

{Option :} [This amount cannot be finally determined until the end of the current Policy Term; that

calculation is based on the formula shown in the Aggregate Benefit Schedule.]

{Option :}
[AGGREGATE ATTACHMENT POINT (Corridor) means the percentage of anticipated Aggregate Eligible Claims Expenses which the Policyholder must pay before an Aggregate Benefit becomes payable to the Policyholder. {Option:} [The Aggregate Attachment Point (Corridor) shown in the Aggregate Benefit Schedule, is used to determine the Aggregate Factor for the Policy Term.]

{Option :}
[AGGREGATE BENEFIT means a benefit that is paid when Aggregate Eligible Claims Expenses actually Paid by the Policyholder on all Covered Units in a Policy Term exceed the Annual Aggregate Deductible shown in the Aggregate Benefit Schedule.]

{Option:}
[AGGREGATE ELIGIBLE CLAIMS EXPENSE means Eligible Claims Expenses that are actually Paid by the Policyholder during the current Policy Term used to calculate the Aggregate Benefit for that Policy Term. This term does not include any Eligible Claims Expenses used to satisfy a Specific Deductible or an Excluded Claim Expense.

Option:}
[MAXIMUM AGGREGATE ELIGIBLE CLAIMS EXPENSE means the maximum dollar amount of Eligible Claims Expenses that are actually Paid by the Policyholder for a [Participant][Family] [Covered Unit] during the current Policy Term which can be used either to satisfy the Annual Aggregate Deductibles or included in the calculation of the Aggregate Benefit for that Policy Term. The Maximum Aggregate Claims Expense is shown in the Aggregate Benefit Schedule.]

{Option without corridor included in the Monthly Aggregate Factor:}
[MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month in [the Policy Term][the period from * through *], A times B, where:

A = The Aggregate Factor per Covered Unit

B = The number of Covered Units as reported by the Policyholder [or the Policyholder's Claims Administrator at the start of that Policy Month.]

{Option, with corridor included:}
[MONTHLY AGGREGATE DEDUCTIBLE AMOUNT means, for each Policy Month in [the Policy Term][the period from * through *], A times B times C, where:

A = The Aggregate Factor shown in the Aggregate Benefit Schedule

B = The number of Covered Units reported by the Policyholder [or the Policyholder's Claims Administrator at the start of that Policy Month.]

C = The Aggregate Attachment Point (Corridor)

{Option :}
[AGGREGATE FACTOR means the dollar amount shown in the Aggregate Benefit Schedule.]

{Option :}
[AGGREGATE PAYABLE PERCENTAGE means the percentage of the Aggregate Benefit, otherwise payable to the Policyholder that will be paid when Aggregate Eligible Claims Expenses, which are actually Paid by the Policyholder in the current Policy Term, exceed the Aggregate Attachment Point (Corridor).]

APPLICANT means the entity; that has contracted with us to provide Stop Loss coverage.

APPLICATION means the written request of an entity through its duly authorized representative(s) for insurance under this Policy on a form acceptable to us.

CATASTROPHIC CLAIM means any Known claim for a Covered Claim Expense Incurred, or expected to be Incurred by a Participant that may reasonably be assumed will exceed 50% {Option :} [of the Specific Deductible] [or] {Option :} [10%] [25%] [50%] [of the] [Annual Aggregate Deductible in the current or next Policy Term.

{Option:}
[CLAIM INFORMATION means to provide Complete Details following a Diligent Review of the data requested by us in connection with the application for, or renewal of, this Policy on any claim incurred, paid or pended {Option :} [30] [45] [60] [90] [120] [180] [270] [365] [days] prior to the beginning of any Policy Term or prior to a Material Change, Claim Information includes but is not limited to Catastrophic Claims, Large Claims and Shock Losses.]

COMPLETE DETAILS means detailed information including, but not limited to the Participant's name and social security number, date of birth, diagnosis, prognosis (unless prognosis cannot be obtained due to reasons beyond the Policyholder's or the Policyholder's Claims Administrators control), and provider name on any Participant covered by, or eligible for coverage, under a Covered Underlying Plan. For purposes of privacy, a unique identifier may be used to identify the Participant in lieu of the person's name, social security number and date of birth.

COVERED CLAIMS BASIS means the time period shown in the {Option :} [Specific Benefit Schedule] {Option :} [and the] [Aggregate Benefit Schedule] {Option; standard incurred & paid :} [during which an Eligible Claims Expense must be Incurred and the time period during which an Eligible Claims Expense must be actually Paid by the Policyholder in any Policy Term. The Covered Claim Basis is shown in the {Option :} [Specific Benefit Schedule] {Option :} [and the Aggregate Benefit Schedule].

COVERED SERVICE or SERVICES means a service, supply or treatment for which the Participant has incurred an Eligible Claims Expense and for which benefits are payable through the Covered Underlying Plan(s). This does not include any service excluded under Special Risk Limitations.

COVERED UNDERLYING PLAN(S) means the plans which are identified in this Policy. This does not include any plan excluded under Special Risk Limitations.

COVERED UNIT or COVERED UNIT(S) means a group of one or more Participants composed of one or more of the following types of Covered Units:

1. Single - a single employee, associate or member); or

2. Single Plus One - a single employee, associate or member and one eligible dependent; or

3. Single Plus Two – a single employee, associate or member and two eligible dependents; or

4. Family - the family of an employee, associate or member); or

5. Composite - the employee, associate or member and all members of his or her family.

The number of Covered Units is used to calculate the premium due each month. The estimated number and type of Covered Units for the first Policy Month of the current Policy Term is shown under Number of Covered Units in the {Option :} [Specific Benefit Schedule] {Option :} [and the] [Aggregate Benefit Schedule].

DEDUCTIBLE(S) means the Specific Deductible, Alternative Specific Deductible, or Aggregate Deductible, as shown in the Specific Benefit Schedule, the Aggregate Benefit Schedule or the Special Risk Limitation Rider.

CLAIMS ADMINISTRATOR means the third party administrator designated by the Policyholder and approved by us. The Claims Administrator is shown in the Declaration Page.

DILIGENT REVIEW means a complete review by the Policyholder or Policyholder's Claims Administrator of the Covered Underlying Plan prior to the beginning of any Policy Term for Known potential Large Claims. The potential for a Large Claim is Known if prior to the beginning of any Policy Term or prior to a Material Change a reasonable person could assume the Policyholder or the Policyholder's Claims Administrator has actual information about such claim.

{Option :}
[DISCLOSURE OR DISCLOSED means to provide Complete Details and any other documentation requested following a Diligent Review including but not limited to census information and Claim Information prior to the beginning of any Policy Term or prior to a Material Change.]

{Option :}
[DISCLOSURE FORM OR DISCLOSURE STATEMENT means the document signed by the Policyholder following a Diligent Review that provides information, upon which we will rely, in part, to issue the Policy.]

{Option :}
[DOMESTIC CLAIMS mean a claim for a Covered Service received by a Participant at a facility provided by the Policyholder or an Affiliate.

EFFECTIVE DATE means the date shown on the cover page of this Policy.

ELIGIBLE CLAIMS EXPENSE means an expense for a Covered Service which is Incurred by a Participant and for which benefits have been actually Paid by the Policyholder in accordance with the terms of the Covered Underlying Plan(s). This term does not include an expense:

1. Not specifically included under the terms of the Covered Underlying Plan;,or

2. Excluded under the terms of the Covered Underlying Plan; or

2. Excluded under the terms of this Policy including Excluded Claims Expenses, if any, shown in Special Risk Limitations.

{Option :} [Eligible Claims Expenses may include any applicable surcharges assessed by state and/or federal rules, laws, or regulations but do not include any additional surcharges or penalties imposed by such rules, laws or regulations.]

This term does not include any Excluded Claims Expenses in Special Risk Limitations on the Declaration Page attached to this Policy.

{Option :}
[EXCLUDED CLAIMS EXPENSES means expenses which are Incurred by a Participant for services, supplies and treatment for, or related to, the condition, or resulting complications, of an injury or sickness described in Special Risk Limitations.]

{Option :}
FAMILY means an employee, associate or member of the Policyholder, and the eligible dependents of such person who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

INCURRED means the date a Participant receives a service, supply or treatment for an Eligible Claims Expense.

{Option :}
[ALTERNATE SPECIFIC DEDUCTIBLE means a separate Specific Deductible, if any, shown in Special Risk Limitations for certain [Participants] [Families] identified in the Policy which must be satisfied prior to any Specific Benefit becoming payable with respect to such [Participant] [Family].]

KNOWN means information affecting the administration or underwriting of this Policy, which a reasonable person can assume the Policyholder or the Policyholder's Claims Administrator had knowledge of prior to a request for [Disclosure] [or] Claim Information or prior to a Material Change.

MATERIAL CHANGE or CHANGE means an action by the Policyholder that may have an economic impact on our liability under this Policy. Material Changes include, but are not limited to, the following:

1. Changes in:

    a. The information [Disclosed or] submitted by the Policyholder upon which our assessment of risk was based; or
    b. The Covered Underlying Plan(s); or
    c. The Claims Administrator.

2. An increase or decrease of the number of [Participants] [Covered Units] by more than [10] [15] [20] [25] % {Option :} in any Policy Month {Option; standard :} [from the Effective Date of this Policy or the date of the last Policy Anniversary, whichever is the later date].

3. A merger, acquisition, divestiture or similar transaction involving the Policyholder.

4. A bankruptcy proceeding involving the Policyholder or an Affiliate.

5. Any other change in factors bearing on the risk assumed by us, including but not limited to the age, sex, geographic location and occupation of Participants, or a change in law or legislation changes the nature of the risk assumed by us under this Policy

This term does not include a change in the Covered Underlying Plan required by state or federal law.

{Option :}
[MAXIMUM AGGREGATE BENEFIT means the maximum dollar amount we will pay the Policyholder for the Aggregate Benefit in the current Policy Term. The Maximum Aggregate Benefit is shown in the Aggregate Benefit Schedule.]

{Option :}
[MAXIMUM SPECIFIC BENEFIT means the maximum dollar amount we will pay the Policyholder per [Participant] [Family] for the Specific Benefit {Options :} [in any Policy Term] {Option :} [or] [during that Participant's lifetime] [while all members of the Family are living]. The Maximum Specific Benefit is shown in the Specific Benefit Schedule.]

{Option :}
[MINIMUM AGGREGATE DEDUCTIBLE means A multiplied by B, where:

A = The [estimated] number of Covered Units shown on the census submitted by the Policyholder, which we used to determine the Premium for the first month of the [initial] [current] Policy term

B = The number of months applicable to [the Paid period for] [the] [initial] [current] [that] Policy Term].

{Option :} [Times {Options :} [80] [85] [90] [95]%.]

{Option :}
[MINIMUM AGGREGATE DEDUCTIBLE means the dollar amount shown in the Aggregate Benefit Schedule for the current Policy Term.]

PAID means the date:

1. Eligible Claims Expenses have been adjudicated and approved by the Policyholder or the Policyholder's Claims Administrator; and

2. A check or draft for remuneration has been issued and deposited in the U.S. Mail (or other similar conveyance), or is otherwise delivered to the payee electronically or in person; or a credit transaction has been agreed to by the Policyholder or the Policyholder's Claims Administrator and received by to the payee electronically or in person; and

3. Sufficient funds are on deposit the date the check or draft is issued to permit the check or draft to be honored; or a sufficient line of credit exists to honor the check, draft or transaction.

A claim will not be considered actually Paid until all of these conditions are satisfied. A draft or check returned to the Policyholder or Claims Administrator for any reason, or any credit transaction not honored by the payee for any reason will not be considered actually Paid.

For purposes of this definition, "payee" means a Participant that received the Covered Service or the health care provider that provided the Covered Service to the Participant.

PARTICIPANT or PARTICIPANTS means a person who is an employee, associate or member of the Policyholder or Affiliate, and the dependents of such persons who are covered, or who become eligible for coverage, through a Covered Underlying Plan.

POLICY means this contract between the Policyholder and us with respect to Stop Loss Insurance.

POLICY ANNIVERSARY means each anniversary of the Effective Date of this Policy, unless changed by agreement between the Policyholder and us.

POLICY MONTH means successive intervals of time, while this Policy is in effect, determined on a monthly basis starting on the Effective Date of this Policy. Each new interval will begin on a day that corresponds to the Effective Date of this Policy. If there is no such day in any applicable month, then the last day of the month will be used.

POLICY TERM means the time period shown in the Declaration Page. For purposes of this definition:

1. An initial Policy Term is the period of time from the effective date of the policy to the date of the first Policy Anniversary.

2. A current or renewal Policy Term is the period of time either from the effective date of the Policy, or the date of the last Policy Anniversary, to the date of the next Policy Anniversary.

Each Policy Term after the initial Policy term will begin on the Policy Anniversary. The initial Policy Term will begin on the Effective Date of this Policy.

POLICYHOLDER means the entity shown on the cover page of this Policy.

PREMIUM DUE DATE means the Effective Date of this Policy and the first day of each following Policy Month.

LARGE CLAIM, SHOCK CLAIM OR SHOCK LOSS means any loss that is reasonably likely to result in a potentially Catastrophic Claim, or any other loss due to the nature of the injury, illness or diagnosis that

the Policyholder or the Policyholder's Claims Administrator reasonably assumes will result in a significant medical expense in the current or next Policy Term.

SPECIAL RISK LIMITATION means any modification of the terms or conditions of this Policy.

[SPECIFIC BENEFIT means the benefit paid when Eligible Claims Expenses actually Paid by the Policyholder for a [Participant] [Family] in any Policy Term exceed the Specific Deductible.]

{Option :}
[SPECIFIC DEDUCTIBLE means the dollar amount which must be satisfied prior to any Specific Benefit becoming payable. The Specific Deductible is shown in the Specific Benefit Schedule.]

{Option :}
[SPECIFIC PAYABLE PERCENTAGE means the percentage of the Specific Benefit, otherwise payable to the Policyholder, that will be paid when Eligible Claims Expenses, which are [actually] Paid by the Policyholder for a Participant, exceed the Specific Deductible. The Specific Payable Percentage is shown in the Specific Benefit Schedule.]

STOP LOSS INSURANCE means the coverage provided under this Policy, which provides benefits to the Policyholder when Eligible Claims Expenses which are [actually] Paid by the Policyholder through the Covered Underlying Plan(s) exceed the levels defined in this Policy.

UNDERLYING PLAN(S) means the employee benefit plans of the Policyholder which provide the benefits identified in the {Option:} Specific Benefit Schedule {Option:} [or the] [Aggregate Benefit Schedule] to the Policyholder's or an Affiliate's employees, associates or members and their dependents. This Policy insures the Policyholder for excess losses through the employee benefit plans identified in this Policy as a Covered Underlying Plan. This term does not include any employee benefit plan of the Policyholder that is not identified as a Covered Underlying Plan in this Policy.